

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			06759		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			90		Registration Dist. No. <u>183</u>	
Village or City <u>Hess Corner</u>			(No. )		St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John Albright</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, <u>married</u> MARRIED WIDOWED OR DIVORCED (Write the word)				
6 DATE OF BIRTH <u>Oct 22 1971</u> (Month) (Day) (Year)						
7 AGE <u>5-8 yrs. 7 mos. 21 ds.</u> If LESS than 1 day... hrs. 1 day... hrs. 21 ds. or min. ?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Blacksmith</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Retired</u>						
9 BIRTHPLACE (State or country) <u>Balto county Md</u>						
10 NAME OF FATHER <u>Charles Albright</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>						
12 MAIDEN NAME OF MOTHER <u>Margaret Waltermire</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Raymond Albright</u> (Address) <u>Monkton Md.</u>						
15 Filed <u>June 15 1970</u> <u>Thomas R. Brown</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>June 12 1970</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>April 5 1970</u> , to <u>June 12 1970</u> , that I last saw him alive on <u>June 12 1970</u> , and that death occurred on the date stated above, at <u>1 A.M.</u>						
The CAUSE OF DEATH was as follows: <u>Chronic Valvular heart disease</u>						
(Duration) <u>5 yrs. 7 mos. 21 ds.</u>						
Contributory Secondary <u>Bronchial asthma</u> (Duration) <u>8 yrs. 7 mos. 21 ds.</u>						
(Signed) <u>William H. Hays</u> M.D. <u>6/15 1970</u> (Address) <u>Baltimore</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death <u>5 yrs. 7 mos. 21 ds.</u> In the State, <u>5 yrs. 7 mos. 21 ds.</u>						
Where was disease contracted, if not at place of death?						
Former or usual residence						
19 PLACE OF BURIAL OR REMOVAL <u>Goodwill cem</u>						
DATE OF BURIAL <u>June 15 1970</u>						
20 UNDERTAKER <u>Edmundson</u>						
ADDRESS <u>Janet H. Hays</u>						



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

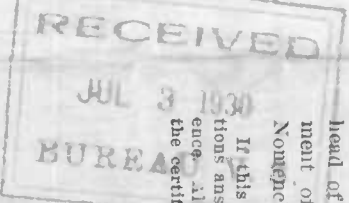
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite"); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asystole," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence; all the data is essential and must be obtained before the certificate is permanently filed.





WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Harford

Village or City Fallston (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2 FULL NAME John J. Alexander

STATE OF MARYLAND  
CERTIFICATE OF DEATH 60

Registration Dist. No. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH July 17, 1860  
(Month) (Day) (Year)

7 AGE 70 yrs. 0 mos. 28 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Scotland

10 NAME OF FATHER Wm Alexander

11 BIRTHPLACE OF FATHER (State or country) Scotland

12 MAIDEN NAME OF MOTHER Christina McLean

13 BIRTHPLACE OF MOTHER (State or Country) Scotland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm John Alexander  
(Address) Fallston Md.

15 Filed Aug 16 1930 W E Richardson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 25 1930 to August 12, 1930  
that I last saw him alive on August 12 1930

and that death occurred on the date stated above, at U m.

The CAUSE OF DEATH \* was as follows:  
Sarcoma of Bladder

Contributory Secondary Sarcoma of Bladder  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Hugh R. Bradley M. D.  
Aug 16 1930 (Address) Jarrettsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St John Cath. Bur. DATE OF BURIAL Aug 18, 1930

20 UNDERTAKER Houderges & Gross ADDRESS Benson Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. hausion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Harford</u>		05619		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Joppa</u> (No. <u>1</u> )		74a		Registration Dist. No. <u>180</u>	
2 FULL NAME <u>Jamur Harry Allen</u>				(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>Aug</u> <u>9</u> , 18 <u>61</u> (Month) (Day) (Year)					
7 AGE <u>68</u> yrs. <u>8</u> mos. <u>28</u> ds. If LESS than 1 day ____ hrs. or ____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Mechanic</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Canada</u>					
PARENTS	10 NAME OF FATHER <u>Alex. Allen</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Canada</u>				
	12 MAIDEN NAME OF MOTHER <u>McGillivray</u>				
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Canada</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>H. D. Allen</u> (Address) <u>Joppa, Md.</u>					
15 Filed <u>May 7</u> 19 <u>30</u> <u>Fred. K. Krolch</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 7</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from 192____ to _____, 192____, that I last saw him alive on _____, 192____, and that death occurred on the date stated above, at <u>2 P</u> m. The CAUSE OF DEATH * was as follows:					
<u>Cerebral Artery aneurysm</u>					
(Duration) ____ yrs. ____ mos. ____ ds.					
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.					
(Signed) <u>May 7</u> 19 <u>30</u> (Address) <u>W. H. Rock</u> M. D. <u>Edg. E. Wood</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.					
Where was disease contracted, if not at place of death? _____					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Abingdon M.E. Cemetery</u>				DATE OF BURIAL <u>May 10</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Howard K. McComas</u>				ADDRESS <u>Abingdon, Md.</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITING ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County HarfordVillage or City Fallston Md. (No. \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 182

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME C Archer Amos

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Oct. 18 1866  
(Month) (Day) (Year)

7 AGE 63 yrs. 5 mos. 27 ds. If LESS than 1 day, \_\_\_\_ hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Carlin Amos11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Annanda Holland13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. Archer Amos(Address) Fallston Md.15 Filed Apr 15 1930 W E Richardson

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 18, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Did not attendthat I last saw him alive on 4/18 1930and that death occurred on the date stated above, at 4 p.m.

The CAUSE OF DEATH \* was as follows:

Cerebral Haemorrhage

Contributory Cerebral Haemorrhage (Duration) Sudden  
Secondary (Duration) Sudden

(Signed) Wm. Stirling M. D.  
4/15/30 1930 (Address) Fallston Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. to the State, \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Friendship W. O. Cemetery DATE OF BURIAL April 16, 193020 UNDERTAKER W. G. Walker ADDRESS Forest Hill Md.



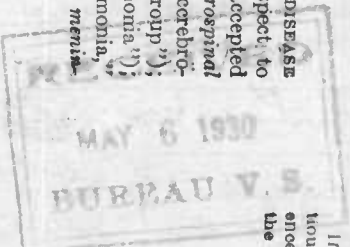
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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Pneumonia* ("Pneumonia," *lobar pneumonia*, *Pneumococcus pneumonia* ("Pneumonia," *lobar pneumonia*, *Pneumococcus pneumonia*), *Tuberculosis of lungs*, *meningitis*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "roup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as *Asthenia, "Anaemia"* (merely symptomatic), *"Atrophy," "Collapse," "Coma," "Convulsions," "Debility"* ("Congenital," "Senile," etc.), *"Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness,"* etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as *"PUERPERAL septicæmia," "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Howard

Village or City Long Branch (No. \_\_\_\_\_)

2 FULL NAME Matilda Armstrong

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Feb 15, 1876  
(Month) (Day) (Year)

7 AGE 54 yrs. 1 mos. 11 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Geo. Talbot

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jebe Hudsonson

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kevin Armstrong

(Address) Edgewood

15 Filed Mar 29 1930 Fred. Morlock Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 26, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 19 19230 to Mar 26, 19230

that I last saw him alive on Mar 26, 19230

and that death occurred on the date stated above, at 4 P m.

The CAUSE OF DEATH \* was as follows:

Broncho-Pneumonia

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 7 ds.

Contributory Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Chas. Rock M. D.

Mar 27 19230 (Address) Edgewood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Mountain Cemetery DATE OF BURIAL March 30, 1930

20 UNDERTAKER Howard K. McNamee ADDRESS Edgewood



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 3 1936  
BUREAU V. B.



# STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

## 1 PLACE OF DEATH

County Berford State Maryland Registered No. 181  
Township Aberdeen Proving Ground or Village \_\_\_\_\_ or  
City Aberdeen Proving Ground No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

## 2 FULL NAME George Aronemann, Private, Army "F" 22nd CA U.S. Army ASN 6702283

(a) Residence. No. Aberdeen Proving Ground, Md. Ward. Bronx, New York City, N.Y.  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) May 7, 1911

7 AGE Years 19 Months 1 Days 0 If LESS than 1 day, --- hrs. or --- min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work SOLDIER U.S. Army

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York City  
(State or country) New York

10 NAME OF FATHER Unknown Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)

14 Informant Capt. A.A. Allen, CAC  
(Address) Aberdeen Proving Ground, Md.

15 Filed June 9, 1930 Orion Mitchell  
11-3184 REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th 19 30

17 I HEREBY CERTIFY, That I attended deceased from

June 7th 19 30 to June 7th 19 30  
that I did not see him alive on June 7th

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_\_,  
and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH\* was as follows:

Accidental drowning

(duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY None  
(SECONDARY)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted  
if not at place of death? no

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) Aberdeen Proving Ground, M. D.

, 19 (Address)

\* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Bronx, New York, N.Y. DATE OF BURIAL June 11, 1930

20 UNDERTAKER R. Mitchell ADDRESS Avre de Grace

A. Madson Mitchell Md.

MARGIN RESERVED FOR BINING

8-200 d  
V. S. No. 98

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

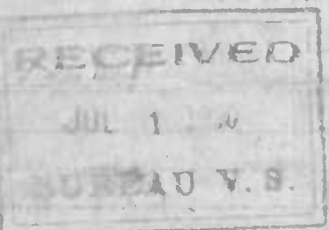
**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia," (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Insanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**NOTE.**—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form is used in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, callusitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.





N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City White Hall, Maryland

2 FULL NAME Joseph Norman Cyrus

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 183

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 19, 1905  
(Month) (Day) (Year)

7 AGE 25 yrs. 2 mos. 15 ds. If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9 BIRTHPLACE (State or country) Harford Co. Md.

10 NAME OF FATHER J. Lupton Cyrus

11 BIRTHPLACE OF FATHER (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER May Mullineaux

13 BIRTHPLACE OF MOTHER (State or country) Harford Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. J. Lupton Cyrus  
(Address) White Hall, Md.

15 Filed Oct. 17 1930 Thomas R. Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the decedent from 192 to 192, that I last saw him alive on 192, and that death occurred on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH \* was as follows:  
Automobile accident causing fracture left side of skull  
laceration of head & face with hemorrhage (Duration) Instantly yrs. mos. ds.

Contributory  
Secondary

(Signed) Chas. C. Cyrus M. D.  
Oct. 16, 1930 (Address) White Hall, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cyrus Chapel DATE OF BURIAL Oct 18, 1930

20 UNDERTAKER P. Macklinson ADDRESS White Hall, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford

15043

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 182Village or City Bel Air Md (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Annie E Bachtel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widow</u>
------------------------	---------------------------------	--

6 DATE OF BIRTH

Mar 27, 1857  
(Month) (Day) (Year)

7 AGE

73 yrs. 8 mos. 20 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer)House duties

9 BIRTHPLACE (State or country)

Md

10 NAME OF FATHER

J. Glenn McComas

11 BIRTHPLACE OF FATHER (State or country)

Katharine Pennington Md

12 MAIDEN NAME OF MOTHER

Katharine Pennington

13 BIRTHPLACE OF MOTHER (State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Geo Forsythe  
Bel Air Md

(Address)

15 Filed Dec 20 1930 W E Chambers

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 17, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov 16 1930 to Dec 17, 1930.that I last saw her alive on Dec 17, 1930.and that death occurred on the date stated above, at 7 A m.

The CAUSE OF DEATH \* was as follows:

Aquina Pectorisunknown

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) A. F. Vane Tibber M. D.Dec 18 1930 (Address) T. Bel Air, Md

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bakers CemeteryDec 20, 1930

20 UNDERTAKER

ADDRESS

Dean & FosterBel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 8 1931

BUREAU



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

NOTE--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

05621

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 181

Village or City Aberdeen (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John Harrison Baker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

Sept 1<sup>st</sup> 1849  
(Month) (Day) (Year)

7 AGE

Eighty yrs. 7 mos. 11 ds. or min.?  
(If LESS than 1 day, hrs.)

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer)

Retired

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

George H. Baker

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Greenland

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Warren Leroy Baker

(Address)

3213 N. Calvert St. Baltimore

15 Filed

Apr 2 19230

Registrar

20 UNDERTAKER

19 PLACE OF BURIAL OR REMOVAL

Baker Cemetery

DATE OF BURIAL

May 3, 1930.

ADDRESS

Aberdeen Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

16 DATE OF DEATH

May 1 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

May 1929 to May 1930  
that I last saw him alive on April 26, 1930.

and that death occurred on the date stated above, at 2 a m.

The CAUSE OF DEATH \* was as follows:

Central Hemorrhage

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
SecondaryParalysis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Dr. J. H. Smith

M. D.

5-119230

(Address)

Baltimore Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

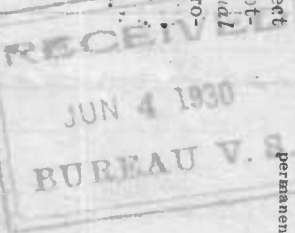
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationery person, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Clothing*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Gold mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH; the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia," *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. . . . . the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

WITHIN CORPORATE LIMITS

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Eden Grace (No. \_\_\_\_\_)

St.: \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME James Balderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Child

6 DATE OF BIRTH Aug 31, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or 15 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Harford Md

10 NAME OF FATHER Roy Balderson III

11 BIRTHPLACE OF FATHER (State or country) Colona Md

12 MAIDEN NAME OF MOTHER Lidia Tatum

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Balderson

(Address) Colona Md

15 Filed Aug 31, 1930 by Chas. J. Foley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 31, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 31, 1930 to Aug 31, 1930, that I last saw him alive on Aug 31, 1930, and that death occurred on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH \* was as follows:

Premature  
Placenta praevia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) James Balderson M. D.  
Aug 31, 1930 (Address) Liberty Ave. Md

State the Disease Causing Death, of, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Colona Md DATE OF BURIAL Sept 1, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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<sup>1</sup> PLACE OF DEATH

County Harford

WITHIN CORPORATE LIMITS OF

90

09317

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Laurel Grove 312 S. Union Ave

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME

Lillian Mary Baldwin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH

Jan 27 1871  
(Month) (Day) (Year)

7 AGE

59 yrs. 8 mos. 1 ds. or 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

House Duties

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Samuel D. Ricketts

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Balinda Bowen

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James H. Baldwin

(Address)

312 S. Union Ave

15

Filed Aug. 26 1930 Charles J. Foley, M.D.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 28 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended the deceased from Aug 6 1930 to Aug 23 1930, that I last saw her alive on Aug 23 1930, and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH \* was as follows:

Systolic Enterters  
Myocarditis

(Duration) yrs. 1 mos. 1 ds.

Contributory Secondary

Toxaemia

(Duration) yrs. 1 mos. 1 ds.

(Signed)

Charles J. Foley

M. D.

Aug 26 1930 (Address) Laurel Grove, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Angel Hill Cem Aug 26 1930

20 UNDERTAKER

ADDRESS

A. Madison Mitchell Laurel Grove, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return 'Laborer,' 'Foreman,' 'Manager,' 'Dealer,' etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Insanition," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
SEP 5 1930  
BUREAU V



MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

W B--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Harford

Village or City Cherdown (No. \_\_\_\_\_)

<sup>2</sup> FULL NAME Mary V. Baldwin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH March 18, 1929  
(Month) (Day) (Year)

7 AGE 1 yrs. 1 mos. 0 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Frederick B. Baldwin

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hazel B. Whitford

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Frederick B. Baldwin  
(Address) Cherdown Md.

15 Filed April 24 1930 O. F. Meck  
Registrar

04368

(51)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar. 15 1930 to April 24 1930  
that I last saw him alive on \_\_\_\_\_, 192\_\_.

and that death occurred on the date stated above, at 3:15 P. M.  
Possibly got limb caught between slats of crib.

The CAUSE OF DEATH was as follows:  
Fracture right femur  
X-ray picture did not show fracture, was a  
acute articular rheumatism

Doctor's diagnosis: acute articular rheumatism  
(Duration) 1 1/2 yrs. 1 mos. 0 ds.

Contributory Cardiac Failure  
Secondary

(Duration) 1 yrs. 1 mos. 0 ds.  
(Signed) Charles J. Foley M. D.

4/24 1930 (Address) Cherdown Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Home Cemetery April 24, 1930

20 UNDERTAKER ADDRESS

Henry Tammings Sons Cherdown Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

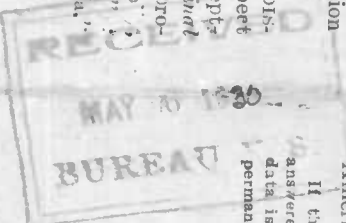
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Labor pneumonia* *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ironition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Reckless wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. . . . the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

Village or City

Harre de Grace

2 FULL NAME

Pauline Barnes

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Sept. 5, 1930

7 AGE

— yrs. 3 mos. 4 ds. or min.?

If LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF  
FATHER

Unknown

11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER

Katherine Barnes

13 BIRTHPLACE  
OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Katherine Barnes

(Address)

Harre de Grace Md.

15

Filed Dec. 9, 1930 Charles J. Foley Registrar

15044

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

St.: Ward)

(If death occurred in  
a hospital or institu-  
tion, give its NAME in  
stead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 9, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
192 to 192that I last saw her alive on Dec 9, 1930  
and that death occurred on the date stated above, at 4:30 A.M.  
The CAUSE OF DEATH \* was as follows:

Enterocolitis

(Duration) yrs. mos. 3 ds.

Contributory  
Secondary

Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed)

Charles J. Foley M. D.

12/9/1930 (Address) Harre de Grace Md.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place  
of death yrs. mos. ds.In the  
State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. James Cem

Dec 10, 1930

20 UNDERTAKER

ADDRESS

P. Madison Mitchell

N. De Grace Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation, whatever, write *None.*

**Statement of Cause of Death**—Name, first, the (initials) CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory"; *Recommenda-* *tions on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931

BUREAU OF



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford

13832

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 184Village or City Whitford (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Henry Barrett

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH <u>June 5, 1912</u> (Month) (Day) (Year)
--

7 AGE <u>18</u> yrs. <u>5</u> mos. <u>8</u> ds. or min.?	If LESS than 1 day hrs.
---	-------------------------

8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed or (employer)
---

9 BIRTHPLACE (State or country) <u>Whitford Md U.S.A</u>
--

10 NAME OF FATHER <u>Joseph Barrett</u>
--

11 BIRTHPLACE OF FATHER (State or country) <u>U.S.A</u>
---

12 MAIDEN NAME OF MOTHER <u>Rachel Jones</u>
---

13 BIRTHPLACE OF MOTHER (State or country) <u>Whitford Md U.S.A</u>
---

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. M. Griffith Jr.(Address) Whitford Md15 Filed Nov. 13 1913 H. J. B. Rabb  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>Nov 13</u> <u>November</u> (Month) <u>13</u> (Day) <u>1930</u> (Year)
---

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192that I last saw him alive on Nov 13, 1930and that death occurred on the date stated above, at P. m.

The CAUSE OF DEATH \* was as follows:

Electrocution through contact with live wire  
Coroner's jury verdict of negligence (Duration) 0 yrs. 0 mos. 0 ds.  
of Line Company

(Signed) Dr. J. M. Griffith Jr. M.D.  
Nov 13 1930 (Address) Whitford Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.	In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.
--	---

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL <u>State Ridge Cemetery</u>	DATE OF BURIAL <u>Nov 15, 1930</u>
--	---------------------------------------

20 UNDERTAKER <u>Dr. J. M. Griffith Jr.</u>	ADDRESS <u>Dallas</u>
--	--------------------------



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Chlostridium pneumoniae* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
DEC 4 1930  
BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

09318

(48)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 182Village or City Hickory (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Cornelius Barrow

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Dec 13, 1854  
(Month) (Day) (Year)

7 AGE 75 yrs. 8 mos. 1 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farm  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER James S. Barrow

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Elyza W Bull

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Barrow(Address) Bel Air Md

15 Filed Aug 15 1930 V. E. Chambers  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 1929 to Aug 14, 1930.

that I last saw him alive on Aug 14, 1930.

and that death occurred on the date stated above, at 5 P. m.  
The CAUSE OF DEATH \* was as follows:

Epithelioma of nose(Duration) 3 yrs. 6 mos. 0 ds.Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Willard P. Hudson M. D.  
Aug 15 1930 (Address) Forest Hill Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Thomas Run M.E. DATE OF BURIAL Aug 16, 1930

20 UNDERTAKER Dean & Fitch ADDRESS Bel Air Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Annie Van Court.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer; Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 6 1920  
BUREAU OF



MARGIN RESERVED FOR BINDING



V. S. No. 1.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Towson

Village or City Neon Normansville Md (No. 7142)

2 FULL NAME Annie Barton

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 183

St.: \_\_\_\_\_ Ward: \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH June - 27<sup>th</sup>, 1858  
(Month) (Day) (Year)

7 AGE 72 yrs. 3 mos. 11 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION (a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Waters

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eunice Low

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie Trout

(Address) Same as above

15 Filed Oct 9 1930 Thomas R. Brown Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 8<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct. 4<sup>th</sup> 1930 to Oct. 8<sup>th</sup> 1930, that I last saw her alive on Oct. 5<sup>th</sup> 1930, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH \* was as follows:

Apoplexy

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Arterio Sclerosis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Secondary Valvular Disease

(Signed) Vallie Galovics M.D.  
Oct. 9 - 1930 (Address) Same as above

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Same as above DATE OF BURIAL Oct 11, 1930

20 UNDERTAKER J. H. Heston ADDRESS Same as above



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 6 1930

BUREAU



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Harford

Village or City Neon Garrisonville-Md- (No. 91-2)

2 FULL NAME William M. Barton

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 183

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single  
6 DATE OF BIRTH Feb - 1<sup>st</sup> 1847 (Month) (Day) (Year)  
7 AGE 83 yrs. 8 mos. 7 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Barton

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ann Morris

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nannie Barton

(Address) Town Group Pz

15 Filed Oct 9 1930 Thomas R. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct - 8<sup>th</sup> 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct. 1<sup>st</sup> 1930 to Oct. 8<sup>th</sup> 1930, that I last saw him alive on Oct - 1<sup>st</sup> 1930

and that death occurred on the date stated above, at 7 a.m.  
The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis  
causing swelling of limbs & etc.  
(Duration) None yrs. mos. ds.

Contributory Secondary Same

(Signed) Stallie Hawkins M. D.  
Oct. 9<sup>th</sup> 1930 (Address) Town Group Pz

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Town Group M.P. Cemetery DATE OF BURIAL Oct. 10<sup>th</sup> 1930

20 UNDERTAKER W. H. Webb ADDRESS Town Group Pz



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

RECEIVED

NOV 8 1920

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Emaciation," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Harford

12893

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

182

Village or City

Emmorton

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Kenneth Sherman Barulich

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

May 28, 1930  
(Month) (Day) (Year)

7 AGE

4 yrs. 5 mos. 5 ds. or min.?

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)9 BIRTHPLACE  
(State or country)

Harf. Co., Md

10 NAME OF  
FATHER

Royal Francis Barulich

11 BIRTHPLACE  
OF FATHER  
(State or country)

N.Y.

12 MAIDEN NAME  
OF MOTHER

Pearl D. Mink

13 BIRTHPLACE  
OF MOTHER  
(State or Country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roy Barulich

(Address)

Yoppa, Md

15

Filed

Oct 4 1930 N.E. Richardson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 4

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Oct 2 1930 to Oct 4 1930

that I last saw him alive on Oct 4 1930

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Broncho-pneumonia  
Secondary to Bronchitis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 2 ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

Willard O. Hudson

M. D.

Oct 4 1930 (Address) Forest Hill, Md

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.In the  
State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Glenville

DATE OF BURIAL

Oct 6 1930

20 UNDERTAKER

The Father

ADDRESS

Yoppa Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

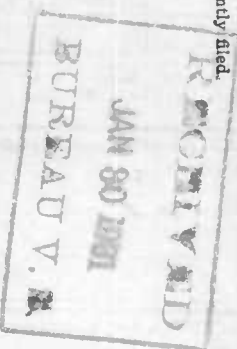
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS OF

13833

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Harrod, Grace 509 Otsego

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John William Bauer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Oct. 15, 1868

(Month)

(Day)

(Year)

7 AGE

68

yrs.

mos.

27

ds.

If LESS than  
1 day.....hrs.  
or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

John Bauer

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

(un.) Clayton

13 BIRTHPLACE OF MOTHER

(State or Country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Elizabeth Bauer

(Address)

509 Otsego Street

15 Filed

Nov. 13, 1920

1920

Chas. J. Tobey M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 11, 1920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Nov. 10<sup>th</sup> 1920 to Nov. 11<sup>th</sup> 1920,that I last saw him alive on Nov. 11<sup>th</sup> 1920,

and that death occurred on the date stated above, at 11:55 A.M.

The CAUSE OF DEATH \* was as follows:

Paralysis

(Duration) yrs. mos. ds.

Contributory  
Secondary

Arterio-sclerosis

(Duration) yrs. mos. ds.

(Signed)

James H. Bay

M. D.

Nov. 12<sup>th</sup> 1920

(Address) Home Dr. House, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Angel Hill Cem

Nov. 14, 1920

20 UNDERTAKER

ADDRESS

H. Madison Mitchell



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same acronymed term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the facts are essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU OF



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hampden

Village or City Abingdon Md (No. \_\_\_\_\_)

2 FULL NAME Infant Bawroski

05622

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH May 28, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Lawyer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Mike Bawroski

11 BIRTHPLACE OF FATHER (State or country) Poland

12 MAIDEN NAME OF MOTHER Anicea Jastrzebski

13 BIRTHPLACE OF MOTHER (State or country) Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mike Bawroski

(Address) Abingdon Md

15 Filed May 29 1930 Fred Morlok local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 28 1930 to May 28 1930.

that I last saw him alive on \_\_\_\_\_, 1930,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows: \_\_\_\_\_

Still Born

Contributory Secondary (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Chas. Richardson M. D. May 29 1930 Address Abingdon

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL On Farm near Abingdon DATE OF BURIAL May 30, 1930

20 UNDERTAKER Howard K McNamee ADDRESS Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railing train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 5 1909  
BUREAU OF



WRITE IN PENCIL, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford

WITHIN CORPORATE LIMITS OF

03014

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180Village or City Harre de Grace (No.     ) Hospital      St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME William Green Bea

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored 5 SINGLE, Single  
~~MARRIED~~  
~~WIDOWED~~  
~~OR DIVORCED~~  
(Write the word)6 DATE OF BIRTH March 1, 1930  
(Month) (Day) (Year)7 AGE      If LESS than 1 day.... hrs.  
..... yrs. .... mos. .... 5 da. or .... min. ?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer)     

## 9 BIRTHPLACE

(State or country) Maryland

## 10 NAME OF FATHER

Charles Green

## 11 BIRTHPLACE OF FATHER

(State or country) Maryland

## 12 MAIDEN NAME OF MOTHER

Beatrice Bea

## 13 BIRTHPLACE OF MOTHER

(State or country) Virginia

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Beatrice Bea(Address) W. Aberdeen, Md.

15

Filed Mar 7 1930 Chas. J. Foley, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 7, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Mar 3, 1930, to Mar 7, 1930.that I last saw her alive on Mar. 7, 1930.and that death occurred on the date stated above, at      PM.

The CAUSE OF DEATH was as follows:

Inter cranial Hemorrhage  
due to delivery P.O.P.Contributory  
Secondary(Duration)      yrs. .... mos. 5 da.(Duration)      yrs. .... mos. 2 da.(Signed) Charles J. Foley M.D.3/17, 1930 (Address) Harre de Grace

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death      yrs. .... mos. .... da. In the State,      yrs. .... mos. .... da.Where was disease contracted, if not at place of death?     Former or usual residence     

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

County Cemetery March 7, 1930

## 20 UNDERTAKER

## ADDRESS

Pennington + Son Hd Grace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired) G. pros.*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 dx.; *Bronchopneumonia* (secondary), 10 dx. Never report mere symptoms or terminal condition, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Coll.-psy," "Cama," "Convulsions," "Debility" ("Congenital," "Sedlie," etc.), "Dropy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—Homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (R commendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1930  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

WITHIN CORPORATE LIMITS OF

0496

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

June 6, 1847  
(Month) (Day) (Year)

7 AGE

87 yrs. 7 mos. 5 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Baker

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF FATHER

FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Jan 14, 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 11, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec. 8th 1929 to Jan 11th 1930,

that I last saw him alive on Jan 11th 1930,

and that death occurred on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH \* was as follows:

Hypostatic Pneumonia  
with a bronchus over labor in type  
Cubor.

(Duration) yrs. 7 mos. 5 ds.

Contributory Cause of Death

(Duration) yrs. 2 mos. 2 ds.

(Signed) James H. Bay M. D.

Jan 11th 1930 (Address) Room 12, Prince, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, it not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Angel Hill Cem. Jan 14, 1930

20 UNDERTAKER

ADDRESS

H. Madison 1238 N. St.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1930  
BUREAU U. S.



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Joppa (No. \_\_\_\_\_)

2 FULL NAME Isaac Martin Bennett

15045 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH July 4, 1845  
(Month) (Day) (Year)

7 AGE 85 yrs. 5 mos. 22 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Builder  
(b) General nature of industry business, or establishment in which employed or (employer) Builder

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Isaac H. Bennett

11 BIRTHPLACE OF FATHER (State or country) Conn

12 MAIDEN NAME OF MOTHER Anna E. Harrison

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Geo Richardson

(Address) Joppa Md

15 Filed Dec. 26, 1930 Fred H. H. Clark  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 19, 1930 to Dec 24, 1930, that I last saw him alive on Dec 24, 1930

and that death occurred on the date stated above, at 8:35 P m.  
The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary

(Signed) Chas. R. H. Edgwood M. D.  
Dec 25, 1930 (Address) Edgwood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore City DATE OF BURIAL Dec 27, 1930

20 UNDERTAKER Howard H. McElm ADDRESS Honolulu



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 5 1901  
BUREAU V. B.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Hartford

04369

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 183Village or City Normsville (No. 74-a)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME in full, street and number.)

2 FULL NAME Galena D. Cunningham

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH November 9, 1862  
(Month) (Day) (Year)

7 AGE 67 yrs. 5 mos. 21 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Arthur Lincoln

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Carrie Houston

13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Lincoln(Address) Sam Sore Pa

15 Filed May 1, 1930 Thomas R. Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 30, 1930  
(Month) 30 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 20, 1930 to April 29, 1930, that I last saw her alive on April 29, 1930,

and that death occurred on the date stated above, at 8:00 p. m.

The CAUSE OF DEATH \* was as follows:

Left. Hemiplegia. Cerebral Hemorrhage.

Contributory (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Secondary Left Hemiplegia. Cerebral Hemorrhage

(Signed) W. H. Smithson M. D.  
April 30, 1930 (Address) New Park, Pa

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Normsville Ind May 3, 1930

20 UNDERTAKER ADDRESS

J. H. Hobbs Sam Sore Pa



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Corioma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1930  
BUREAU



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford15046 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 183Village or City Near Jarrettsville (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME George T. Bevard

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)
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6 DATE OF BIRTH  
May 9, 1853  
(Month) (Day) (Year)7 AGE  
77 yrs. 8 mos. 8 ds. or min. ?  
If LESS than 1 day.... hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work..... Farmer  
(b) General nature of industry business, or establishment in which employed or (employer).....9 BIRTHPLACE  
(State or country) Harford Co. Md.10 NAME OF FATHER  
James Bevard11 BIRTHPLACE OF FATHER  
(State or country) Harford Co. Md.12 MAIDEN NAME OF MOTHER  
Jemima Street13 BIRTHPLACE OF MOTHER  
(State or country) Harford Co. Md.14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
Martha E. Bevard  
(Informant)(Address) Rocks, Md.15 Filed Dec. 19 1930 Thomas R. Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Dec 17, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
Dec 10, 1930, to Dec 17, 1930.  
that I last saw him alive on Dec 17, 1930,  
and that death occurred on the date stated above, at 104 yrs.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage + Chronic  
Paraneuronal NephritisContributory  
Secondary(Duration) 4 yrs. 3 mos. 0 ds.  
(Signed) A. F. Bradley M. D.  
Dec 17 1930 (Address) Jarrettsville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL  
Bethel Cem. DATE OF BURIAL  
Dec. 19, 193020 UNDERTAKER  
E. G. Kurtz & Son ADDRESS  
Jarrettsville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Retired* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Drou"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin, "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 40 ds. Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracina," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 2 1931

BUREAU V. S.



WRITING ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Pleasantville Md (No. \_\_\_\_\_)10463 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 182

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME J. Frank Billingslea

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Mar. 19 1884  
(Month) (Day) (Year)

7 AGE 51 yrs. 5 mos. 21 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Jacob Billingslea

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Ely

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion Whittaker(Address) Forest Hill Md.

15 Filed Sept. 11, 1930 N. E. Richardson  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 10, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Sept. 10, 1930, that I last saw him alive on Sept. 9, 1930, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH \* was as follows:

Acute Myocarditis

Contributory Inflammatory  
Secondary Rheumatism

(Signed) W. M. Stirling M. D.  
9/11/30 (Address) Hallston Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State, \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baptist Cemetery DATE OF BURIAL Sept. 12, 1930

20 UNDERTAKER H. G. Walker ADDRESS Forest Hill Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

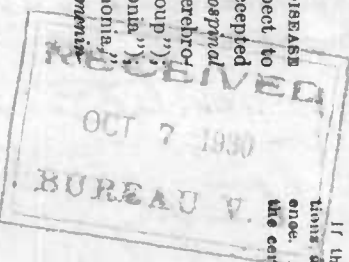
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupations**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Driver," etc., without more precise specification as *Hay laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite, avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (dispose causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If the certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Hartford</u>		04370 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Rocks</u> (No. _____) St. _____ Ward _____		Registration Dist. No. <u>193</u>	
2 FULL NAME <u>Susan Jane Blaney</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, <u>widowed</u> MARRIED, WIDOWED OR DIVORCED (Write the word)	
6 DATE OF BIRTH <u>May 2</u> , 18 <u>83</u> (Month) (Day) (Year)			
7 AGE <u>76</u> yrs. <u>11</u> mos. <u>22</u> ds. or min. ? If LESS than 1 day.....hrs.			
8 OCCUPATION (a) Trade, profession or particular kind of work..... <u>none</u> (b) General nature of industry business, or establishment in which employed or (employer)..... <u>none</u>			
9 BIRTHPLACE (State or country) <u>Hartford co md</u>			
PARENTS	10 NAME OF FATHER <u>Emmanuel Nagle</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>		
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Howe</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>md</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>George Blaney</u> (Address) <u>Rocks md</u>			
15 Filed <u>Apr 25</u> 19 <u>30</u> <u>Thomas P Brown</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>April 23</u> , 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>April 16</u> , 19 <u>30</u> , to <u>April 23</u> , 19 <u>30</u> , that I last saw her alive on <u>April 22</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>3</u> pm. The CAUSE OF DEATH was as follows: <u>Myocarditis + Corona</u> <u>Nephritis + Hypertension</u> (Duration) ..... yrs. .... mos. .... ds. Contributory Secondary (Duration) ..... yrs. .... mos. .... ds. (Signed) <u>M. E. Patton</u> M. D. <u>April 23</u> , 19 <u>30</u> . (Address) <u>Candy md</u> *State the Disease Causing Death, or, Deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death..... yrs. .... mos. .... da. In the State, ..... yrs. .... mos. .... da. Where was disease contracted, if not at place of death? Former or usual residence.....			
19 PLACE OF BURIAL OR REMOVAL <u>Holy cross cam.</u>		DATE OF BURIAL <u>April 26</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Edmundson</u>		ADDRESS <u>Sanitelle</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Steward*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 30 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 5 1920

BUREAU



WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City

Glenville

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Baby Bluino

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

wh

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

May 18

(Month)

(Day)

1930  
(Year)

7 AGE

miscarriage

yrs.

mos.

ds.

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF  
FATHER

Jewel Thomas Bluino

11 BIRTHPLACE  
OF FATHER  
(State or country)

Ashe co. N.C.

12 MAIDEN NAME  
OF MOTHER

Myrtle Belle Brinegar

13 BIRTHPLACE  
OF MOTHER  
(State or Country)

N.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Bluino

(Address)

Hawre De Grace

15

Filed May 19 1930

D. N. E. Richardson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 18

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192\_\_ to

192\_\_

that I last saw him alive on

192\_\_

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Still-born (miscarriage at  
5th mo)

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Willard P. Hudson

M. D.

May 18 1930

(Address)

Forest Hill, Md

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the

State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Garden

DATE OF BURIAL

May 18 1930

20 UNDERTAKER

none

ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 6 1930  
BUREAU OF



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Grafton Shaps (No. \_\_\_\_\_)

2 FULL NAME Elizabeth Bond

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, Widowed  
MARRIED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH About - July - 1840  
(Month) (Day) (Year)

7 AGE About 90 yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?  
If LESS than  
1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Basis C. Kess

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jehu Nelson Johnson  
(Address) 2514 Oak St - Balto. Md.

15 Filed Oct. 25 1930 V. E. Chambers  
Registrar

12490

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 22 1930 to Oct 24 1930,

that I last saw her alive on Oct 22 1930,

and that death occurred on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH \* was as follows:

Chr. Myocardial Disease  
(Duration) 4 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) Willard B. Hudson M. D.  
Oct 25 1930 (Address) Forest Hill, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Fairview - M.E. DATE OF BURIAL Oct 27, 1930

20 UNDERTAKER Dean & Foster ADDRESS Bu Air, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

NOV 8 1900

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by hydrobolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, thrombus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Abersdeen (No. \_\_\_\_\_)

2 FULL NAME John Bond

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Nov. 3, 1930  
(Month) (Day) (Year)

7 AGE Still Born If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Harford Co. Md

10 NAME OF FATHER Harry Clark

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Linda Bond

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. John Homer  
(Address) Abersdeen Md

15 Filed Nov. 4, 1930 O. B. Michael  
Registrar

13834

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 3, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192 \_\_\_\_ to \_\_\_\_\_ 192 \_\_\_\_

that I last saw him alive on \_\_\_\_\_ 192 \_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Still Born  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) O. B. Michael (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. Local Registrar  
M. P.  
192 \_\_\_\_ (Address) Abersdeen Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, it not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Not Calvary Cem DATE OF BURIAL Nov 4, 1930

20 UNDERTAKER Burned by flash of ADDRESS Abersdeen Md  
child



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 6 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

(90)

05624 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City Bell Air, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Frances Bond

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE Cal 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH unknown  
(Month) (Day) (Year)

7 AGE 65 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work House duties  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Bruce Bond

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Hall

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver Brown

(Address) Bell Air Md

15 Filed May 5 1930 Virginia E. Chambers  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 5, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1928 to May 5, 1930.

that I last saw her alive on May 5, 1930.

and that death occurred on the date stated above, at 10<sup>15</sup> A. m.

The CAUSE OF DEATH \* was as follows:

Myocarditis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Chas. Keen M. D.

May 5 1930 (Address) Bell Air Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Heister Hill May 7, 1930

20 UNDERTAKER ADDRESS

Dean & Foster Bell Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 6 1904

BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

WITHIN CORPORATE LIMITS OF

01721

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than

1 day hrs.

1 day hrs.

1 day hrs.

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF

FATHER

11 BIRTHPLACE

OF FATHER

(State or country)

12 MAIDEN NAME

OF MOTHER

13 BIRTHPLACE

OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows

Contributory  
Secondary

(Signed)

Feb 15 1930

(Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

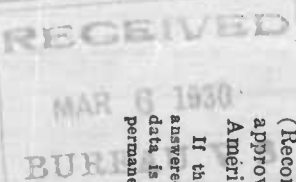
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operations was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory," (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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<sup>1</sup> PLACE OF DEATH  
County Harford

Village or City Joppa (No. 44)

<sup>2</sup> FULL NAME Harry Borchardt

0495

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 180

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Nw 9, 1867  
(Month) (Day) (Year)

7 AGE 62 yrs. 1 mos. 17 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Joining  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Borchardt

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Heckworth

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. H. Borchardt

(Address) Joppa

15 Filed Jan 5 1930 Fried. Morlok local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 11 1929 to Jan 4, 1930  
that I last saw him alive on Jan 4, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Carcinoma of Esoph

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Chas. Port M. D.  
Jan 5 1930 (Address) Edgewood Md

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Trinity Luthern Cemetry Jan 7, 1930

20 UNDERTAKER

ADDRESS

Howard K. McComas

Abingdon, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 5 1930  
BU



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## 1 PLACE OF DEATH

County

Harford

Village or City

Rocks

(No.)

St.: Ward)

Registration Dist. No. 184

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

Infant Bosley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

July 14, 1930

(Month)

(Day)

(Year)

7 AGE

yrs. mos. ds.

If LESS than

1 day. / hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Wilbur Bosley

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Sadie R. Kennedy

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wilbur Bosley

(Address)

Rocks Md

15

Filed

July 14, 1930 H. J. McCrell

Registrar

08076

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 14, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

July 14, 1930 to July 14, 1930

that I last saw him alive on July 14, 1930

and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH \* was as follows:

Haemorrhage on the brain

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Charles W. Rogers M. D.

July 14, 1930 (Address) 1000 18th St

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Highland Cemetery July 15, 1930

20 UNDERTAKER

ADDRESS

D. W. McCrell 1000 18th St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Chopnauonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

REVISED  
MAY 6 1930  
BUREAU



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1 PLACE OF DEATH County <u>Harford</u>			08077 (90)			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Castleton</u> (No. <u>-</u> )			St. <u>-</u> Ward <u>-</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>Joseph F. Bostic</u>			Registration Dist. No. <u>184</u>					
PERSONAL AND STATISTICAL PARTICULARS						MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE <u>WIDOWED</u> (Write the word)	16 DATE OF DEATH <u>July 16</u> , 19 <u>30</u> (Month) (Day) (Year)					
6 DATE OF BIRTH <u>Oct. 28</u> , 18 <u>55</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan. 1</u> , 19 <u>20</u> to <u>July 16</u> , 19 <u>30</u> that I last saw him alive on <u>July 15</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>8 A.</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic myocarditis</u> (Duration) <u>10</u> yrs. <u>-</u> mos. <u>-</u> ds.					
7 AGE <u>74</u> yrs. <u>8</u> mos. <u>19</u> ds. or <u>-</u> min.?			If LESS than 1 day <u>-</u> hrs. <u>-</u> min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>-</u>			Contributory Secondary (Duration) <u>-</u> yrs. <u>-</u> mos. <u>-</u> ds.					
9 BIRTHPLACE (State or country) <u>Pa</u>			(Signed) <u>W. H. Gallon</u> M. D. <u>July 16</u> , 19 <u>30</u> (Address) <u>Darlington</u>					
PARENTS	10 NAME OF FATHER <u>Frank Bostic</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
	11 BIRTHPLACE OF FATHER (State or country) <u>Pa</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>-</u> yrs. <u>-</u> mos. <u>-</u> ds. In the State <u>-</u> yrs. <u>-</u> mos. <u>-</u> ds.					
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>		Where was disease contracted, if not at place of death? <u>-</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>		Former or usual residence <u>-</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>E. J. Bostic</u> (Address) <u>Darlington, Md</u>								
15 Filed <u>July 16</u> , 19 <u>30</u> <u>M. H. Reik</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Darlington Cemetery</u>			DATE OF BURIAL <u>July 19</u> , 19 <u>30</u>		
			20 UNDERTAKER <u>H. S. Bailey</u>			ADDRESS <u>Darlington, Md.</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Harlington (No. \_\_\_\_\_)

2 FULL NAME Mary H. Botts

04371

(124)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 184

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 ~~SINGLE~~ MARRIED Married  
~~WIDOWED~~  
~~OR DIVORCED~~  
(Write the word)

6 DATE OF BIRTH March 31, 1859  
(Month) (Day) (Year)

7 AGE 71 yrs. 0 mos. 1 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER John Moore

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Herr

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Elsie Botts

(Address) Harlington, Md.

15 Filed April 1, 1930 M. H. Kils Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 1, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1, 1929 to April 1, 1930, that I last saw her alive on March 31, 1930

and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH \* was as follows:

Chronic Cholecystitis

Contributory  
Secondary

(Duration) 2 yrs. 6 mos. \_\_\_\_ ds.

Natural

(Signed) F. P. Sinsgrace M. D.

4-1-30 (Address) Harlington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Dublin L.M. Cem. DATE OF BURIAL April 3, 1930

20 UNDERTAKER A. S. Bailey ADDRESS Harlington, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE P. WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS

113

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

185

Village or City

Sussex Creek

(No. ....)

St. .... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mary E. Bousquet

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

July 17 - 1930  
(Month) (Day) (Year)

7 AGE

- yrs. 3 mos. 4 ds. or min.?

If LESS than 1 day.....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

George Bousquet

11 BIRTHPLACE OF FATHER

(State or country)

New York

12 MAIDEN NAME OF MOTHER

Iduna Babbity

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Bousquet

(Address)

Clare de Grace Rd

15

Filed

Oct 23 1930 Charles J. Foley

Registrar

16 DATE OF DEATH

Oct 23 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sep 15 1930 to Oct 23 1930 that I last saw her alive on Oct 22 1930

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH \* was as follows:

Dis. Colitis

Contributory Secondary

Exhaust

(Signed)

A. B. Skene

M. D.

Oct 23 1930

(Address) Harris of Grimes

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.

In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hoffman Chapel

10/23 1930

20 UNDERTAKER

ADDRESS

Birmingham Son Elder Grace



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Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc.; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH		STATE OF MARYLAND	
County <u>Harford</u>		CERTIFICATE OF DEATH	
Village or City <u>Cheriden</u> (No. <u>R.T.D.</u> )		St. _____	Ward _____
2 FULL NAME <u>Ruthene Bowen</u>		Registration Dist. No. <u>181</u>	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	
6 DATE OF BIRTH <u>Feb</u> <u>19</u> <u>1887</u> (Month) (Day) (Year)			
7 AGE <u>73</u> yrs. <u>3</u> mos. <u>1</u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
10 NAME OF FATHER <u>Henry S. Andrew</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
12 MAIDEN NAME OF MOTHER <u>Mary Oliver</u>			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ireland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Miss. Mollie C. Andrew</u> (Address) <u>Cheriden Md. R.T.D.</u>			
15 Filed <u>May 22</u> 192 <u>30</u> <u>C. Michael</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May</u> <u>20</u> , 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>May 8</u> 19 <u>30</u> to <u>May 20</u> , 19 <u>30</u> that I last saw her alive on <u>May 18</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>11:10 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Pneumonia (Broncho)</u> (Duration) <u>0</u> yrs. <u>0</u> mos. <u>12</u> ds. Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Chas. A. Kist</u> M. D. <u>May 20</u> 19 <u>30</u> (Address) <u>Cheriden Md</u> State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Babes Cemetery</u>		DATE OF BURIAL <u>May 23</u> 19 <u>30</u>	
20 UNDERTAKER <u>Henry Tarrington</u>		ADDRESS <u>Cheriden Md</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum, etc., (Corcinoma, Sarcoma, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *A accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUN 4 1950

BUREAU V. S.



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## 1 PLACE OF DEATH

County

Harford

CORPORATE LIMITED

161-a

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Hdelrace (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

(Baby) Bower

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Sept. 6 - 1930

(Month)

(Day)

(Year)

7 AGE

— yrs. — mos. — ds. or min.?

If LESS than

1 day, 3 hrs.

## OCCUPATION

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Maryland.

10 NAME OF  
FATHER

Clarence Bower

11 BIRTHPLACE  
OF FATHER

(State or country)

Maryland.

12 MAIDEN NAME  
OF MOTHER

Anastasia Simpers

13 BIRTHPLACE  
OF MOTHER

(State or Country)

Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. John Simpers

(Address)

Hdelrace, Md.

15 Filed

Sept. 8 1930

1930

Charles J. Foley, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 6

1923

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Sept 6

1923

to Sept 6

1923

that I last saw him alive on Sept 6, 1923

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Permatomy

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

F. M. Steiner

M. D.

7-7

1923

(Address)

Haven de Grace

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Angel Hill Cem.

Sept. 7, 1930

20 UNDERTAKER

ADDRESS

Perryman, Md. Hdelrace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary; or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashtemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Seaford*

06761

(122-a)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *185*Village or City *Havre de Grace* (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME *David Bowman*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Black*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Married*

6 DATE OF BIRTH

*- unknown**1890*

(Month)

(Day)

(Year)

7 AGE

*abt 40 yrs.**unknown*If LESS than  
1 day.....hrs.  
1 mos.....ds. or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Labor on R.R.*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)*Virginia*10 NAME OF  
FATHER*Unknown*11 BIRTHPLACE  
OF FATHER

(State or country)

*N*12 MAIDEN NAME  
OF MOTHER*11*13 BIRTHPLACE  
OF MOTHER

(State or Country)

*15*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs. Rutha Bowman*

(Address)

*Havre de Grace*

15

Filed

*June 2 1930*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*June 1, 1930*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

*May 12 1930 to June 1 1930*that I last saw him alive on *May 31, 1930*and that death occurred on the date stated above, at *4:00* m.

The CAUSE OF DEATH \* was as follows:

*Cirrhosis of Liver  
Alcohol*

(Duration) ..... yrs. .... mos. .... ds.

Contributory  
Secondary*Exhaustion Cardiac  
Failure*

(Duration) ..... yrs. .... mos. .... ds.

(Signed)

*Charles J. Foley M. D.**6/1 1930* (Address) *Havre de Grace*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. .... mos. .... ds.

In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Union County**June 4, 1930*

20 UNDERTAKER

ADDRESS

*Remington Dr**Havre de Grace*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Imanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 5 1918  
BUREAU V. S.



MARGIN RESERVED FOR BIRMINGHAM, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

WITHIN CORPORATE LIMITS OF

05626 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Hampden (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Martha E. Bowen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE B 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

6 DATE OF BIRTH Dec 12 1874  
(Month) (Day) (Year)

7 AGE 55 yrs. 5 mos. 11 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Home work  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Samuel White

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. R. Bowen  
(Address) Hampden

15 Filed May 24 1930 Chas. J. Foley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 22, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 15 1930 to 5-22 1930  
that I last saw her alive on 5-23 1930.

and that death occurred on the date stated above, at 10 P. m.  
The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) R. D. ... M. D.  
5-22 1930 (Address) Hampden

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hampden A.M.E. Church May 25 1930

20 UNDERTAKER ADDRESS

Wm. J. ... Hampden



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

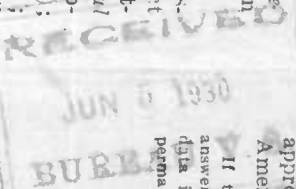
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever (it is only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia, Bronchopneumonia ("Pneumonia,"*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, "Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





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<sup>1</sup> PLACE OF DEATH  
County Harford

Village or City Belair (No. 0)

2 FULL NAME Anna Mary Bradley

08078

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Feb. 14, 1880  
(Month) (Day) (Year)

7 AGE 50 yrs. 3 mos. 7 ds. or 4 min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work House Keeper  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Harford Co. Md.

10 NAME OF FATHER Daniel Bradley

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Morie Tahaney

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John J. Bradley

(Address) Belair Md.

15 Filed July 21, 1930 NE Richardson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 15, 1930 to July 20, 1930  
that I last saw her alive on July 19, 1930  
and that death occurred on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH \* was as follows:

Cerebral Embolism

(Duration) 5 yrs. 5 mos. 5 ds.  
Contributory Rheumatic Valvular  
Secondary Heart Disease

(Signed) Willard G. Hudson M. D.  
July 21, 1930 (Address) Forest Hill, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Johns Cemetery, Long Green DATE OF BURIAL July 23, 1930

20 UNDERTAKER Hornberger & Sons ADDRESS Belair Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sprayer, (b) Cotton mill; (c) Salesman, (b) (Grocery); (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling brick—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u>		04372		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Vale</u> (No. _____)		(129)		Registration Dist. No. <u>182</u>	
2 FULL NAME <u>Dudley Bradley</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>Apr 8</u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Jan 26</u> , 18 <u>75</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from .....192 <u>9</u> to <u>Apr 8</u> , 19 <u>30</u> that I last saw him alive on <u>Apr 7</u> , 192 <u>9</u> and that death occurred on the date stated above, at <u>11:45</u> a.m.		
7 AGE <u>55</u> yrs. <u>2</u> mos. <u>13</u> ds. or min.?			The CAUSE OF DEATH * was as follows: <u>Pneumonia outbreak</u> (Duration) <u>2</u> yrs. mos. ds.		
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer) <u>Laborer.</u> <u>Farmer.</u>			Contributory Secondary (Duration) yrs. mos. ds. (Signed) <u>Pennell</u> <u>Apr 9 1930</u> Address <u>Baltimore</u>		
9 BIRTHPLACE (State or country) <u>Virginia</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.		
PARENTS	10 NAME OF FATHER <u>Arthur Bradley</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence		
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>		19 PLACE OF BURIAL OR REMOVAL <u>Talernacle Col Cem.</u>		
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Jones</u>		DATE OF BURIAL <u>Apr 12, 1930</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>		20 UNDERTAKER <u>Hornberger &amp; Gross</u>		ADDRESS <u>Baltimore</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sarah Bradley</u> (Address) <u>Vale, Md.</u>					
15 Filed <u>Apr 9 1930</u> <u>N.C. Richardson</u> Registrar					



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

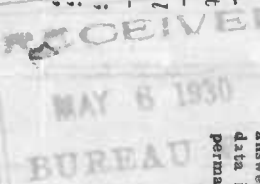
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH, the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Imitation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Harford*STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *182*Village or City *Bel Air Md* No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*John Joseph Bradley, Jr.*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*single*

6 DATE OF BIRTH

*May 26, 1905*  
(Month) (Day) (Year)

7 AGE

*22 yrs. 6 mos. 23 ds.* or min.?

If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Plumber*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Md*

10 NAME OF FATHER

*John J. Bradley*

11 BIRTHPLACE OF FATHER

(State or country)

*Md*

12 MAIDEN NAME OF MOTHER

*Lillian P. Kerr*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*John J. Bradley*

(Address)

*Bel Air Md*

15

Filed *Dec 30 1923* *V E Chambers*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Dec 19, 1923*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*Dec 19, 1923* to *Dec 19, 1923*

that I last saw him alive on \_\_\_\_\_, 1923

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

*Arteriole accident**Strangulation* (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *Chas. Richardson* M. D.*Dec 19, 1923* (Address) *Bel Air Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Long Green**Dec 27, 1923*

20 UNDERTAKER

ADDRESS

*Dean & Fort**Bel Air Md*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1901

BUREAU V. S.



WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

STATE OF MARYLAND  
CERTIFICATE OF DEATH

15048

(K-1)

Registration Dist. No. 184

Village or City

Street

(No. \_\_\_\_\_)

St.: \_\_\_\_\_ Ward: \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Alberta Brison

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Dec 14, 1920  
(Month) (Day) (Year)

7 AGE

yrs. \_\_\_\_\_ mos. 1 ds. or \_\_\_\_\_ min.?

If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Ind.

10 NAME OF FATHER

Ray Brison

11 BIRTHPLACE OF FATHER (State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Blanche Edders

13 BIRTHPLACE OF MOTHER (State or Country)

M.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray Brison

(Address)

Street Ind.

15 Filed

Dec 15 1920 H. J. S. McMath.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 16, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Dec 14, 1920 to Dec 15, 1920

that I last saw him alive on Dec 14, 1920

and that death occurred on the date stated above, at 2 a.m.

The CAUSE OF DEATH \* was as follows:

Premature Birth

Contributory Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds.

(Signed) Charles W. Brison M. D.

Dec 15 1920 (Address) Street Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Rock Cem.

DATE OF BURIAL

Dec. 15, 1920

20 UNDERTAKER

Wiley Edwards

ADDRESS

Bel Air Md.

If more blanks are needed, address State Registrar, 18 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 6 1931

BUREAU



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

WITHIN CORPORATE LIMITS OF

0497

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Shore del Duende Md. (No. 170)

St.          Ward          (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Henry J. Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April 15, 1880  
(Month) (Day) (Year)

7 AGE 49 yrs. 8 mos. 17 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Machinist  
(b) General nature of industry, business, or establishment in which employed or (employer)         

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James W. Brown

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Shorts

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benjamin F. Brown

(Address) Laurel Md.

15 Filed 1/3 1930 Charles J. Foley Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 2, 1930 to Jan 2, 1930, that I last saw him alive on Jan 2, 1930

and that death occurred on the date stated above, at 9:14 P.M.  
The CAUSE OF DEATH \* was as follows:

Suicidal  
Bullet wound of left lung  
Inter abdominal hemorrhage  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Internal Hemorrhage  
Secondary

(Signed) Martine P. Foley Coroner M. D.  
1/3 1930 (Address) Shore del Duende

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Long Hill Cemetery DATE OF BURIAL 1/3 1930

20 UNDERTAKER G. Karsie ADDRESS Laurel Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

FEB 5 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic volubular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE

WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

03015

(9)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City Bel Air, Md. (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Joseph H. Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Coul

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

single

6 DATE OF BIRTH

July 18, 1929  
(Month) (Day) (Year)

7 AGE

yrs. 8

mos. 5

ds. 5

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

J. H. Brown

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Amelia S. Booker

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Booker

(Address)

Bel Air, Md

15

Filed Mar. 24, 1930, Virginia E. Chambers  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 23, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
Mar 22 - 1930 to Mar 23 - 1930

that I last saw him alive on Mar. 22 - 1930

and that death occurred on the date stated above, at 1:50 p.m.

The CAUSE OF DEATH \* was as follows:

Pertussis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 14 ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

A. F. Van Kester M. D.

Mar. 24, 1930 (Address) T. Bel Air, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Henderson Hill

Mar 24, 1930

20 UNDERTAKER

ADDRESS

Dean &amp; Felt

Bel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Stearns

WITHIN CORPORATE LIMITS OF

04373 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Hidespace (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Maud Shure Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 SINGLE, married  
MARRIED, married  
WIDOWED, -  
OR DIVORCED -  
(Write the word)

6 DATE OF BIRTH

August 7, 1868  
(Month) (Day) (Year)

7 AGE

61 yrs. 8 mos. 14 ds. or min.?

If LESS than  
1 day. hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

Housework

9 BIRTHPLACE  
(State or country)

Maryland

10 NAME OF FATHER

Harry Shure

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Georgiana Walz

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Wheeler Brown

Hidespace - Md.

15

Filed

Apr. 24, 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 22, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Sept. 1, 1929, to April 22, 1930,  
that I last saw him alive on April 21, 1930,

and that death occurred on the date stated above, at 29 m.

The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis

Paralysis

Myocarditis

(Duration) yrs. 8 mos. ds.

Contributory  
Secondary

Coronary Failure

(Duration) yrs. 4 mos. 7 ds.

(Signed) Charles J. Foley M. D.

4/24 1930 (Address) Hidespace - Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ashbury Hill Co., Apr. 24, 1930

20 UNDERTAKER

ADDRESS

Perryman &amp; Son Hidespace - Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 5 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			WITHIN CORPORATE LIMITS OF 04374		STATE OF MARYLAND	
County <u>Harford</u>			(18-a)		CERTIFICATE OF DEATH	
Village or City <u>Hdelsrace</u> (No. _____)			Hospital <u>Hdelsrace</u> St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Nervon Bryant</u>			Registration Dist. No. <u>185</u>			
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)				
6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year)						
7 AGE <u>adult</u> yrs. ~ mos. ~ ds. or min. If LESS than 1 day ____ hrs.						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Unknown</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>North Carolina</u>						
10 NAME OF FATHER <u>Unknown</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>						
12 MAIDEN NAME OF MOTHER <u>Unknown</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hdelsrace Hospital</u> (Address) <u>Hdelsrace Road</u>						
15 Filed <u>April 5, 1930</u> by <u>J. Foley, M.D.</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>April 4<sup>th</sup></u> , 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from 192____ to 192____, that I last saw him alive on 192____, and that death occurred on the date stated above, at <u>2:30 A.M.</u> The CAUSE OF DEATH * was as follows: <u>Cerebral hemorrhage due to fracture of Skull, accidentally injured on B &amp; O R Road near Belvidere Station in Cecil County Md.</u> (Duration) ____ yrs. ____ mos. ____ ds. Contributory <u>Accident</u> (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>Martin P. Foley "Coroner"</u> M. D. <u>April 5<sup>th</sup> 1930</u> (Address) <u>Hdelsrace</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>High Point, Md.</u> DATE OF BURIAL <u>Apr 7, 1930</u>						
20 UNDERTAKER <u>Lemington South Hdelsrace</u> ADDRESS _____						



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "(roup)"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 5 1930  
BUREAU OF



WRITE QUICKLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Rock (No. 113)

06762 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

2 FULL NAME James Thomas Buchanan

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 8, 1930  
(Month) (Day) (Year)

7 AGE 8 If LESS than 1 day \_\_\_\_ hrs. 1 day \_\_\_\_ hrs. 2 yrs. \_\_\_\_ mos. 8 ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Leon Buchanan

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Dorsey

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leon Buchanan

(Address) Pikeville Md

15 Filed June 17 1930 H. J. McNabb Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 16, 1930 to June 16, 1930, that I last saw him alive on June 16, 1930, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH \* was as follows:  
Enteritis

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) Charles W. Garrison M. D.  
June 16 1930 (Address) Street 13 Ang

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Christus Boreas June 17, 1930  
20 UNDERTAKER ADDRESS

H. H. Hobb Farm Grove Rd



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BIRMINGHAM  
WRITE PAPER, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
Harford  
County \_\_\_\_\_

10465 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

Village or City Aberdeen, Md (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Golden Burkinn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6 DATE OF BIRTH July 11 1887 (Month) (Day) (Year)

7 AGE 43 yrs. 2 mos. 17 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION (a) Trade, profession or particular kind of work Housework (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Vincent Burkinn 11 BIRTHPLACE OF FATHER Md (State or country)

12 MAIDEN NAME OF MOTHER Amanda Jones

13 BIRTHPLACE OF MOTHER Md (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Burkinn (Address) Aborder, Md.

15 Filed Sept 30 1923 Michael Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 28 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192 and that death occurred on the date stated above, at 5:15 A.M.

The CAUSE OF DEATH \* was as follows: Unknown Patient dead on arrival-I had not attended her before death-had been under care of Dr. F. P. Snodgrass Darlington, Md.

Contributory Secondary Initial respiration, congested (Duration) yrs. mos. ds.

(Signed) T. P. Thompson M. D. Sept 28 1930 (Address) Aberdeen, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Doublet Cem DATE OF BURIAL Oct 1, 1930

20 UNDERTAKER ADDRESS H. S. Bailey Darlington Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugmill, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 5 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 6 1900

BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

15049

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 155

Village or City Gloucester (No.     )

St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Nicolas Buscher

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH unknown 1 (Month) (Day) (Year)

7 AGE abt. 60 yrs.      mos.      ds. or      min. If LESS than 1 day      hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work labor (b) General nature of industry, business, or establishment in which employed or (employer)     

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Buscher

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or Country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Buscher  
(Address) Gloucester, Md.

15 Filed Dec 27 1930 Chas. J. Foley, D.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 24, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 20 to Dec 24, 1930, that I last saw him alive on Dec 24, 1930,

and that death occurred on the date stated above, at      m. The CAUSE OF DEATH \* was as follows:

Acute Cardiac Failure  
(Duration)      yrs.      mos.      ds.

Contributory  
Secondary

(Signed) J. A. Steiner M. D.  
Dec 26 1930 (Address) Harford, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?     

Former or usual residence     

19 PLACE OF BURIAL OR REMOVAL Mt. Zion Cemetery DATE OF BURIAL Dec 27, 1930

20 UNDERTAKER Pennington ADDRESS Gloucester, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 3 1931

BUREAU



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1 PLACE OF DEATH  
County Harford

01723 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City New Janettville

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John T. Cain

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widower

6 DATE OF BIRTH June 26, 1858  
(Month) (Day) (Year)

7 AGE 72 yrs. 1 mos. 10 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Patrick Cain

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Yr

13 BIRTHPLACE OF MOTHER (State or country) \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Paul Cain

(Address) Forest Hill

15 Filed Feb 9 1930 BONE Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 6, 1930  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from Jan. 25<sup>th</sup> 1930 to Feb. 6<sup>th</sup> 1930, that I last saw him alive on Feb. 5<sup>th</sup> 1930,

and that death occurred on the date stated above, at 4 P m.  
The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis  
unknown  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) A. F. Van Gilder M. D.  
Feb 7 1930 (Address) Tel Air, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Hickory Md. DATE OF BURIAL Feb 10, 1930

20 UNDERTAKER Deane & Sons ADDRESS Bel Air, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mooseles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meesles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 5 1910

BUREAU V. S.



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1 PLACE OF DEATH

County

Village or City

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

(If LESS than  
1 day 0 hrs.  
0 yrs. 0 mos. 0 ds. or 0 min.)

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

05627

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward)

(If death occurred in  
a hospital or institution,  
give its NAME in-  
stead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

192 (Address)

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place  
of death yrs. mos. ds.In the  
State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
present residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

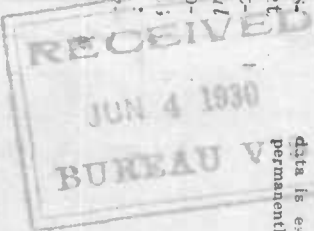
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiovascular fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *septicæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.





MARGIN RESERVED FOR BINDING

WRITE HERE, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS OF

113

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Dover Neck

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Charles Wilson Campbell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

July 15, 1930

(Month)

(Day)

(Year)

7 AGE

3 yrs. 3 mos. 3 ds. or min.?

If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

None

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF  
FATHER

Wilson S. Campbell

11 BIRTHPLACE  
OF FATHER

(State or country)

Md

12 MAIDEN NAME  
OF MOTHER

Dorothy Mouldapple

13 BIRTHPLACE  
OF MOTHER

(State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wilson S. Campbell  
Perryville, Md.

15 Filed

Oct. 26

1930

Chas. J. Foley, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 15, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
Oct 15, 1930 to Oct 15, 1930

that I last saw him alive on Oct 15, 1930

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Dis. Gland.

Contributory  
Secondary

(Duration) yrs. mos. ds.

Exhaustion

(Duration) yrs. mos. ds.

(Signed)

F. H. Steiner

M. D.

Oct 16, 1930 (Address) Perryville, Md.

\*State the Disease Causing Death, or in deaths from  
Violent Causes, state (1) Means of injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospital, Institutions, Trans-  
ients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

North East M.C. &amp; Oct 17, 1930

20 UNDERTAKER

ADDRESS

Lee A. Patterson Perryville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

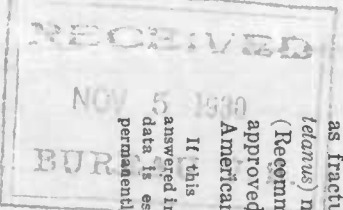
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (c) Solemn, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* as such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Van Bibber (No. ....)2 FULL NAME Edward Carney

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>unknown</u>
----------------------	---------------------------------	---

6 DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)7 AGE about 50 yrs. .... mos. .... ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Unknown  
(b) General nature of industry business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Philadelphia Pa.

10 NAME OF FATHER Unknown  
11 BIRTHPLACE OF FATHER (State or country) Unknown  
12 MAIDEN NAME OF MOTHER Unknown  
13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Greene Jr.(Address) Van Bibber, Md.15 Filed May 2 1930 Fred Morlok Registrar

04799

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 170

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 1, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192,that I last saw him alive on 192,and that death occurred on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH \* was as follows:

Accidental, Killed by P. R. T. Bus on Phila. Road

(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... ds.

(Signed) Fred Morlok Coroner  
April 4, 1930. (Address) Abingdon Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Abingdon Cemetery May 3, 1930

20 UNDERTAKER ADDRESS

Howard K. McComas Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 5 1913



MARGIN RESERVED FOR BINDING  
WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

13835

STATE OF MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH  
County Harford WITHIN CORPORATE LIMITS 88

Registration Dist. No. 175

Village or City Harford (No. Chapel Road St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Thomas Cart

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>Nov. 25, 1930</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>May 12, 1847</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192	
7 AGE <u>83</u> yrs. <u>6</u> mos. <u>13</u> ds. or min.?			that I last saw him live on <u>Nov. 20, 1930</u> and that death occurred on the date stated above, at <u>12:20</u> A.M. The CAUSE OF DEATH * was as follows: <u>Acute Myocarditis</u>	
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer)			Contributory Secondary <u>Pulmonary Embolism</u> (Duration) yrs. mos. ds.	
9 BIRTHPLACE (State or country) <u>Ind.</u>			(Signed) <u>F. N. Steingard</u> M. D. <u>Nov 26 1930</u> (Address) <u>Harford</u>	
10 NAME OF FATHER <u>Wm Cart</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.	
12 MAIDEN NAME OF MOTHER <u>Maria Wilson</u>			Where was disease contracted, if not at place of death?	
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>			Former or usual residence.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Phoebe Cart</u> (Address) <u>Shore de Grace Md.</u>				
15 Filed <u>Nov. 26</u> 19 <u>30</u> <u>Chas. J. Selby M.D.</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Wesleyan Chapel Rd</u> DATE OF BURIAL <u>Nov 25, 1930</u>	
			20 UNDERTAKER <u>V. Madison Mitchell N. de S.</u> ADDRESS <u>Ind.</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scullery, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal meningitis*; *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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U. S. DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS

1930



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u>			15050 160-c			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Wildegrass</u> (No. _____)			St. _____ Ward _____			Registration Dist. No. <u>183</u>		
2 FULL NAME <u>Eugene Castagnera</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)					
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE <u>married</u> MARRIED WIDOWED OR DIVORCED (Write the word)						
6 DATE OF BIRTH <u>May 5</u> , 19 <u>09</u> (Month) (Day) (Year)								
7 AGE <u>21</u> yrs. <u>7</u> mos. <u>16</u> ds. If LESS than 1 day ____ hrs. or ____ min.?								
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Brick Layer.</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____								
9 BIRTHPLACE (State or country) <u>Philadelphia, Pa.</u>								
10 NAME OF FATHER <u>John C. Castagnera</u>								
11 BIRTHPLACE OF FATHER <u>Italy</u> (State or country)								
12 MAIDEN NAME OF MOTHER <u>unknown</u>								
13 BIRTHPLACE OF MOTHER <u>Italy</u> (State or Country)								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Eugene Castagnera</u> (Address) <u>Baltimore, Md.</u>								
15 Filed <u>Dec 22</u> 19 <u>30</u> <u>Charles J. Foley, D.D.</u> Registrar								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>December 22</u> , 19 <u>30</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from 192____ to _____, 192____, that I last saw him alive on _____, 192____, and that death occurred on the date stated above, at <u>12:30 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Cerebral Hemorrhage from Fractured Skull</u>								
Contributory (Duration) ____ yrs. ____ mos. ____ ds. <u>Automobile Accident</u> Secondary								
(Signed) <u>Martin P. Foley</u> Coroner M. D. <u>Dec. 22 1930</u> (Address) <u>Wildegrass, Md.</u>								
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.								
Where was disease contracted, if not at place of death? _____ Former or usual residence _____								
19 PLACE OF BURIAL OR REMOVAL <u>Bowie, Md.</u>						DATE OF BURIAL <u>Dec. 24 1930</u>		
20 UNDERTAKER <u>Billy &amp; Zieles</u>						ADDRESS <u>Balto, Md.</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Crup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 3 1931  
BUREAU



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

Village or City

Forest Hill (No. -)

2 FULL NAME

Lulu R. Cavender

03016

74-a

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

St. - Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

March 28, 1881

(Month)

(Day)

(Year)

7 AGE

48 yrs. 11 mos. 22 ds.

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

David C. Ely

11 BIRTHPLACE

OF FATHER

(State or country)

Md.

12 MAIDEN NAME

OF MOTHER

Mary B. Pyle

13 BIRTHPLACE

OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Parker Cavender

(Address)

Street, Md. R.F.D.

15

Filed

Mar 22 1930

H. E. Richardson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 21, 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Mar 21, 1930 to Mar 21, 1930

that I last saw her alive on Mar 21, 1930

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH \* was as follows:

Hemorrhage of Brain

(Duration) yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

Charles W. Williams

M. D.

Mar 22 1930

(Address)

Street B. and

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emory Cem., March 24, 1930

20 UNDERTAKER

ADDRESS

H. S. Bailey Harlington



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sprinter*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolio acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 5 1930



WRITE PAPER, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Harford

01724

(47)

# STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 182

 Village or City Beltair (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Hannah Chase

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

 6 DATE OF BIRTH About 50 years  
(Month) (Day) (Year)

 7 AGE About 50 years If LESS than 1 day, hrs. or min.?  
yrs. mos. ds.

 8 OCCUPATION  
(a) Trade, profession or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed or (employer)

 9 BIRTHPLACE (State or country) Harford Co. Md

 10 NAME OF FATHER James W. Fleming

 11 BIRTHPLACE OF FATHER (State or country) Balto Co, Md

 12 MAIDEN NAME OF MOTHER Sarah Anderson

 13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Albina Chase  
(Address) Fallston, Md

 15 Filed Mar 2 1930 BONE Richardson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH Feb. 28<sup>th</sup> 1930  
(Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from Feb. 25 1930 to Feb. 28 1930,  
that I last saw her alive on Feb. 27<sup>th</sup> 1930,

 and that death occurred on the date stated above, at 12 m.

 The CAUSE OF DEATH \* was as follows:  
Broncho. pneumonia

 (Duration) yrs. mos. 2 ds.  
Contributory Carcinoma of breast  
Secondary unknow

 (Signed) A. F. Van Bibber M. D.  
Mar 2 1930 (Address) Belt Air, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

 19 PLACE OF BURIAL OR REMOVAL Tahmachi Col Cem DATE OF BURIAL 3/3 1930

 20 UNDERTAKER Horuluger & Gross ADDRESS Benson, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Other pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-aid), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling train—carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

MAR 5 1930

BUREAU V. S.



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Emmorton (No. \_\_\_\_\_)

2 FULL NAME Dorsey Cheet, Cheet

13836

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Nov 25, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Lennie Cheet

11 BIRTHPLACE OF FATHER (State or country) N.C.

12 MAIDEN NAME OF MOTHER Rough Crouse

13 BIRTHPLACE OF MOTHER (State or Country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lennie Cheet  
(Address) Emmorton Md

15 Filed Nov 28 1930 Fred H. Harkins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov. 25 1930 to Nov 27, 1930, that I last saw him alive on Nov 27, 1930,

and that death occurred on the date stated above, at 11<sup>30</sup> a.m.

The CAUSE OF DEATH \* was as follows:

Edema of Lungs (Congestive)  
Intercranial pressure due to rigid sutures  
and no fontanelle visible

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Intercranial Pressure  
Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) M. P.  
Nov 27, 1930 (Address) 1201 E. St.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Int. Cemetery DATE OF BURIAL Nov 28, 1930

20 UNDERTAKER Howard K. McNamee ADDRESS Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BIRTHING  
WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WITHIN CORPORATE LIMITS OF 03017

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 185

1 PLACE OF DEATH

County Harford

Village or City Hd Grace (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Luciel E. Christy

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH March 9, 1880  
(Month) (Day) (Year)

7 AGE 80 yrs. - mos. - ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Isaac Hyson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lloyd Christy  
(Address) Hd Grace Md

15 Filed March 11 1930 Charles J. Foley, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June, 1928 to Mar 9, 1930, that I last saw him alive on Mar 9, 1930,

and that death occurred on the date stated above, at 11 A. m. The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis  
Hypertension  
(Duration) 3 yrs. mos. ds.

Contributory Secondary Cardiac Failure  
(Duration) yrs. mos. 2 ds.

(Signed) Charles J. Foley, M.D.  
3/9, 1930 (Address) Howard St

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. James and Paul DATE OF BURIAL March 11 1930

20 UNDERTAKER Birmingham ADDRESS Hd Grace Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

6498

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

Village or City

Corryman

St.: Ward:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John H. Christy

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Feb

8

1874

(Month)

(Day)

(Year)

7 AGE

55 yrs. 11 mos. 6 ds.

If LESS than 1 day... hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Day Laborer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Harriet Schofield

13 BIRTHPLACE OF MOTHER (State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie E. Kenly

(Address)

15

Filed

Jan 16

1920

O. C. Michael

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 14, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

July

1920 to 1-14

1930

that I last saw him alive on 1-12-1930

and that death occurred on the date stated above, at 1:35 p.m.

The CAUSE OF DEATH \* was as follows:

Paralysis due to Cerebral Hemorrhage

(Duration) yrs. 8 mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) J. H. Olier M. D.

1-14-1930 (Address) Corryman Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union M. E. Cemetery

Jan 14, 1930

20 UNDERTAKER

ADDRESS

Henry Tarnish &amp; Sons

Aberdeen Md

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death); *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1930

BUREAU V. S.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Harford

Village or City Fallston RD 1 (No. \_\_\_\_\_)

<sup>2</sup> FULL NAME Frank P. Clark

12493

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH May 10th, 1 \_\_\_\_\_  
(Month) (Day) (Year)

7 AGE 60 yrs. 5 mos. ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Painter  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Patrick Clark

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Kerr

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clark Fitzpatrick  
(Address) Fallston md

15 Filed Oct 13 1930 V. E. Chambers  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 13th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192\_\_ to \_\_\_\_\_ 192\_\_,

that I last saw him alive on \_\_\_\_\_ 192\_\_,

and that death occurred on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH \* was as follows:

No Physician in attendance

Sudden death

Natural Cause

Acute alcoholism; (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Acute nephritis, congestive.

Contributory Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Virginia E. Chambers Deputy Registrar

Oct 13 1930 (Address) Bel Air, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Francis Cemo. Abingdon, Oct. 16, 1930

20 UNDERTAKER

ADDRESS

McComas & Son, Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1900

BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS OF 03018

M.A.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Harvard Green Hospital

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

James H. Clements Jr

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED, WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

March 29, 1930  
(Month) (Day) (Year)

7 AGE

yrs. mos. ds. or min.

If LESS than  
1 day 3 hrs.  
or min.

8 OCCUPATION

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF  
FATHER

James H. Clements

11 BIRTHPLACE  
OF FATHER  
(State or country)

Maryland

12 MAIDEN NAME  
OF MOTHER

Margaret G. Carter

13 BIRTHPLACE  
OF MOTHER  
(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. James H. Clements Jr

(Address)

Whitman Rd

15

Filed

Mar 29 1930 Chas. J. Jew, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

3/29/30, 192

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

3-29 1930 to 192

that I last saw him alive on Mar 29, 1929

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Premature Infant

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

2/29 1930 (Address) 1800 Green Rd

M. D.

\*State the Cause Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dulles Cemetery

March 30 1930

20 UNDERTAKER

ADDRESS

Henry Tarrington

Whitman Rd



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*; the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 9 1918  
BUREAU OF



WRITE HERE WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County

Harford

04375

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

Village or City

Joppa

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

Stillborn Clouman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Apr 24 1930  
(Month) (Day) (Year)

7 AGE

If LESS than 1 day.....hrs. .... yrs. .... mos. .... ds. or .... min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Infant

9 BIRTHPLACE

(State or country)

Harford Co. Md.

10 NAME OF FATHER

Julian Clouman

11 BIRTHPLACE OF FATHER

(State or country)

Harford Co. Md.

12 MAIDEN NAME OF MOTHER

Norma Decker

13 BIRTHPLACE OF MOTHER

(State or country)

Harford Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs Julian Clouman  
Joppa Md.

15 Filed

April 24 1930 Fred Harford  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 24 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Still Birth

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Apr 24 1930 Address) Edgewood M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Chapel Cem. Apr. 25, 1930

20 UNDERTAKER

ADDRESS

Hornburger &amp; Gross Benson Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sprinter, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Teacher," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scullery, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Carcinoma, Sarcoma, etc., of . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mexles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mexles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling brick—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A like data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 3 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			164		05628		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			WITHIN CORPORATE LIMITS OF		Registration Dist. No. <u>185</u>			
Village or City <u>Stowde Grace</u> (No. <u>102 S. Union Ave</u> )			Str.		Ward)		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mary Ann Cochran</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>						
6 DATE OF BIRTH <u>Oct. 21, 1840</u> (Month) (Day) (Year)								
7 AGE <u>89</u> yrs. <u>7</u> mos. <u>0</u> ds.		If LESS than 1 day.....hrs. or.....min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)		<u>Retired</u> <u>House Duties</u>						
9 BIRTHPLACE (State or country)		<u>Md.</u>						
10 NAME OF FATHER		<u>Geo. Stephenson</u>						
11 BIRTHPLACE OF FATHER (State or country)		<u>Md.</u>						
12 MAIDEN NAME OF MOTHER		<u>Francina Christie</u>						
13 BIRTHPLACE OF MOTHER (State or Country)		<u>Md.</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE								
(Informant) <u>Th. James N. Bay</u>								
(Address) <u>102 S. Union Ave</u>								
15 Filed <u>May 21, 1930</u> <u>Chas. J. Foley, M.D.</u> Registrar								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>May 21, 1930</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from <u>May 14, 1930</u> to <u>May 21, 1930</u> that I last saw her alive on <u>May 20, 1930</u> and that death occurred on the date stated above, at <u>8:30</u> a.m. The CAUSE OF DEATH * was as follows: <u>Infirmitas due to old age</u> (Duration).....yrs.....mos.....ds. Contributory <u>Cardiac &amp; Pulmonary</u> Secondary (Duration).....yrs.....mos.....ds. (Signed) <u>J. Leet Hopkins</u> M. D. <u>May 21, 1930</u> (Address) <u>Stowde Grace</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds. Where was disease contracted, if not at place of death? Former or usual residence.....								
19 PLACE OF BURIAL OR REMOVAL <u>Angel Hill Cem.</u>						DATE OF BURIAL <u>May 23, 1930</u>		
20 UNDERTAKER <u>R. Madison Mitchell</u>						ADDRESS <u>H. D. B. M.</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrub, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Herdler wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

JUN 5 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Near Norrisville Md (No. 113), St.        Ward       

Registration Dist. No. 183

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Cecil Ralph Corner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH January - 19<sup>th</sup>, 1930  
(Month) (Day) (Year)

7 AGE 4 yrs., 2 mos., 2 ds. or        min. ?  
If LESS than 1 day....hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work. none  
(b) General nature of industry business, or establishment in which employed or (employer) ✓

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles Corner

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Blevens

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Corner

(Address) Faun Grove Pk

15 Filed May 22 1930 Thomas P Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May - 21<sup>st</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 21 - 1930 to May 21 - 1930; that I last saw him alive on May - 21<sup>st</sup>, 1930; and that death occurred on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH was as follows:  
Acute indigestion  
filled bowels & stomach with gas  
(Duration) few hours de.

Contributory Secondary

(Signed) Valerie Hawkins M.D.  
May 21 - 1930 (Address) Faun Grove Pk

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death        yrs.        mos.        ds. In the State,        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Norrisville M.P. Cemetery DATE OF BURIAL May - 23, 1930

20 UNDERTAKER W. H. Webb ADDRESS Faun Grove Pk



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Toreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PREPERAL, septicaemia," "PREPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Harford*

WITHIN CORPORATE LIMITS OF (No.)

Village or City

*Oldel Grace, Md.* (No.)

2 FULL NAME

*Joseph Cook*STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *195*

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male colored*

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*

6 DATE OF BIRTH

*Unknown, 1*  
(Month) (Day) (Year)

7 AGE

*abt. 5-3 yrs. - mos. - ds.* If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work *labor*(b) General nature of industry business, or establishment in which employed or (employer) *-*

9 BIRTHPLACE (State or country)

*Maryland*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (State or Country)

*Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Plaza Stansbury  
Oldel Grace, Md.*

15

Filed

*Nov. 5*

1920

*Charles J. Foley M.D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*November 2nd*, 1930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192... to ... 192...

that I last saw him alive on ... 192...

and that death occurred on the date stated above, at *4:47 A.M.*

The CAUSE OF DEATH \* was as follows:

*Chronic Valvular lesion  
of the heart*

(Duration) ... yrs. ... mos. ... ds.

Contributory  
Secondary*Cardiac Failure*

(Duration) ... yrs. ... mos. ... ds.

(Signed)

*Martin P. Foley, Coroner*

M. D.

*Nov. 2nd 1930* (Address) *Oldel Grace*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ... yrs. ... mos. ... ds.

In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Good Court, Oldel Grace, Md.*

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. James Am. E. Rev.**Nov. 6, 1930*

20 UNDERTAKER

ADDRESS

*Remingtonson**Oldel Grace*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1920



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## 1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS OF

(90)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

175

Village or City

Have a grace (No. Have a Grace Hospital)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Harry C. Cook

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Oct. 11<sup>th</sup>, 1860  
(Month) (Day) (Year)

7 AGE

70 yrs. 1 mos. 26 ds. or min.?

If LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Philadelphia, Pa.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Geo. Wilderson

(Address)

Bel Air, Md.

15

Filed

Dec. 7 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 7<sup>th</sup>, 1930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Nov. 5<sup>th</sup>, 1930, to Dec. 7<sup>th</sup>, 1930,that I last saw him alive on Dec. 7<sup>th</sup>, 1930,

and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH \* was as follows:

Senility  
Cardiac Insufficiency

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. S. Starnes, M. D.

19230 (Address) 2140 N. Green St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Friendship cemetery, Dec. 9, 1930

20 UNDERTAKER

ADDRESS

Hoonberg &amp; Gross Benson

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the nearest CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-pulmonary fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 3 1931

BUREAU U. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Village or City

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1920

Registrar

09319

74a

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw her alive on

and that death occurred on the date stated above, at 7:50 A. M.

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

Aug 25 1920 (Address) Aberdeen

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dig laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Muscles (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
SEP 4 1900  
BUREAU V



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

0439

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180Village or City Joppa (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William James Corns

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Jan 24, 1858  
(Month) (Day) (Year)

7 AGE 71 yrs. 11 mos. 27 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farming  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James Corns

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laurel Everett

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. J. Corns(Address) Joppa

15 Filed Jan 23 1930 Fred. M. Worlock Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 15 1920 to Jan 21, 1930

that I last saw him alive on Jan 21, 1930

and that death occurred on the date stated above, at 3:35 P m.

The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Chas. R. Rode M. D.  
Jan 22 1930 (Address) Edgewood

\*State the Disease Causing Death or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Abingdon CemeteryJan. 24, 1930

20 UNDERTAKER

ADDRESS

Howard K. McComasAbingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 5 1900  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Fallston (No. ....)

2 FULL NAME William Wilkinson Corbin

13838

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Nov. 1, 1850  
(Month) (Day) (Year)

7 AGE 80 yrs. - 5 mos. 5 ds. or min. ?  
If LESS than 1 day.....hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm W. Corbin

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Stormer

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. Corbin  
(Address) Fallston Md

15 Filed Nov. 7, 1930 A. E. Chambers  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 6, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 1, 1930 to Nov 6, 1930,

that I last saw him alive on Nov 5, 1930,

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH \* was as follows:

Cerebral Sclerosis  
(Duration) yrs. mos. ds.

Contributory Secondary Cerebral Hemorrhage  
(Duration) yrs. mos. ds.

(Signed) Samuel S. Rappaport M. D.  
Nov 7, 1930 (Address) Bel Air

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Parkwood Cemetery DATE OF BURIAL Nov. 8, 1930

20 UNDERTAKER W. H. Archer ADDRESS Benson Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Ironing*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Cauler," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Chrysipoid fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"; "Typhoid fever" never report "Typhoid Pneumonia," "lobar pneumonia, Bronchopneumonia" ("Pneumonia,"

DEC 5 1930

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A. The date is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BONDING  
WRITE HERE, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Harford

WITHIN CORPORATE LIMITS OF

09320

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Hdels Grace (No. ....)Hospital

St. .... Ward) (If death occurred in

a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Demery Fox

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,

Single  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

August 15, 1900  
(Month) (Day) (Year)

7 AGE

30 yrs. - 0 mos. 0 ds. or min.?IF LESS than  
1 day...hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of worklabor(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

North Carolina10 NAME OF  
FATHERJoe Fox11 BIRTHPLACE  
OF FATHER

(State or country)

North Carolina12 MAIDEN NAME  
OF MOTHERAntonia Casey13 BIRTHPLACE  
OF MOTHER

(State or Country)

North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hdels Grace Hospital

(Address)

Hdels Grace, Md.

15

Filed

Aug 19 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 16, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Aug 9, 1920, to Aug 18, 1920that I last saw him alive on Aug 17, 1920

and that death occurred on the date stated above, at .... m.

The CAUSE OF DEATH \* was as follows:

Suppressed Typhoid

(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... ds.

(Signed)

[Signature] M. D.  
Aug 18, 1920 (Address) Hdels Grace, Md.\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? Trap Hill - N.C.Former or usual residence Trap Hill - N.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elkirk - N.C.Aug. 27, 1930

20 UNDERTAKER

ADDRESS

Pennington & Son Hdels Grace, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For-man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—(Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death, 29 ds; Bronchopneumonia (secondary), 10 ds*. Never report mere symptoms or terminal conditions, such as *Asthemia*, "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 21 1930  
BUREAU OF VITALS



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## 1 PLACE OF DEATH

County Harford

WITHIN CORPORATE LIMITS OF

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Hdelsgrace, (No. \_\_\_\_\_)

St.: \_\_\_\_\_ Ward: \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Infant Presner

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH December 8, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Clarence Presner11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Margaret Spink13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Presner(Address) Hdelsgrace, Md.15 Filed Dec. 9 1930 Clas. J. Foley Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 8, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Dec 8, 1930 to Dec 8, 1930, that I last saw him alive on Dec 8, 1930, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH \* was as follows:

Conjugal Malformation of heart  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary(Signed) Charles J. Foley, M.D.  
12/9 1930 (Address) Harford, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Angel Hill Cem. DATE OF BURIAL Dec. 9, 193020 UNDERTAKER Remington ADDRESS Hdelsgrace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 2 1931

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

WITHIN CORPORATE LIMITS

13839

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Marlboro de Grace (No. in Chesapeake Bay Channel Port Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Thomas Meredith Bromwell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH January 11<sup>th</sup>, 1903  
(Month) (Day) (Year)

7 AGE 27 yrs. 9 mos. 23 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Contractor  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Dr. Martin John Bromwell

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nettie Jenkins

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Franklin Bromwell

(Address) Lake Roland, Md.

15 Filed Nov 3 1920 Charles J. Foley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 2<sup>nd</sup>, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 11<sup>15</sup> P.m.

The CAUSE OF DEATH \* was as follows:

Embolus Brain

(Duration) \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.  
Contributory Cardiac Failure  
Secondary

(Signed) Martin P. Foley, Coroner M. D.  
Nov. 2<sup>nd</sup>, 1920 (Address) Marlboro de Grace, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds. In the State \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New Cathedral Cemetery DATE OF BURIAL 5<sup>th</sup> Nov., 1920

20 UNDERTAKER Henry H. Jenkins & Sons Co ADDRESS McGowan & Orchard



*Pneumonia dead "William the Lion"*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrub, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

DEC 5 1930

BUREAU



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1 PLACE OF DEATH  
County Harford

Village or City Aberdeen Md. P. I. D. (No. 189)

15053 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

2 FULL NAME William Hays Cronin

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH March 13, 1863  
(Month) (Day) (Year)

7 AGE 67 yrs. 9 mos. - ds. or LESS than 1 day - hrs. - min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Benjamin Cronin

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Courtney

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Clarence Cronin  
(Address) Aberdeen Md.

15 Filed Dec 16 1930 O. B. Winkler  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 13, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 13, 1930 to Dec 13, 1930

that I last saw him alive on Nov 10, 1930

and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH \* was as follows:

Accidental Death  
Rachis ribs on right side,  
punctured lungs-

(Duration) 2 yrs. 0 mos. 0 ds.

Contributory  
Secondary

Struck by Bull

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Benjamin Cronin M. D.

Dec 16 1930 (Address) Aberdeen

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death - yrs. - mos. - ds. In the State - yrs. - mos. - ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Love Cemetery

Dec 17, 1930

20 UNDERTAKER

ADDRESS

Henry Tanning Sons Aberdeen Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH state occupation, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931

BUREAU OF VITALS



WRITE PARENTS WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harpur

Village or City Bell Air R. F. L. (No. ....)

2 FULL NAME Josephine Bullum

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH August 29 1930  
(Month) (Day) (Year)

7 AGE 1 yrs. 1 mos. 0 ds. or 1 day 0 hrs. 0 min.?  
If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James Bullum

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Edna Bullum

13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Bullum

(Address) Bell Air R. F. L.

15 Filed Oct 1 1930 Fred H. Harlock Registrar  
Local

10851

(160)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 190

St. .... Ward .... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 29 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 29 1930 to Sept 29 1930  
that I last saw him alive on Sept 20 1930  
and that death occurred on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH \* was as follows:

Mass as follows: primary; not preceded by gastro-enteritis, etc.  
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Signed) Chas. Richardson M. D.  
Sept 30 1930 (Address) Bell Air R. F. L.

\*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belway Cemetery

Oct 1 1930

20 UNDERTAKER

ADDRESS

Howard K. Melburn Abingdon

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

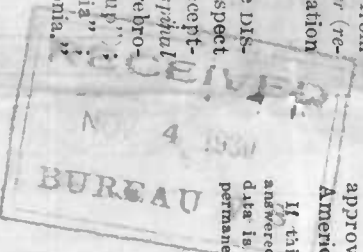
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement: "Never return Laborer," "Foreman," "Miner," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Tuberculous fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masks; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little date is essential and must be obtained before the certificate is permanently filed.





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1 PLACE OF DEATH

County HarfordVillage or City Cherden N.D. (No. 7)2 FULL NAME Mildred E. Curry

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 10, 1930  
(Month) (Day) (Year)

7 AGE 4 yrs. 7 mos. 7 da. or LESS than 1 day hrs. min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

## 9 BIRTHPLACE (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (State or Country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Robert E. Curry(Address) Cherden Md. N.D.15 Filed Nov. 17 1930 C. M. McLean RegistrarSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 181

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 17, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov 17, 1930 to Nov 17, 1930.that I last saw him alive on Nov 16, 1930.and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH \* was as follows:

Dis Colitis(Duration) 17 yrs. 17 mos. 17 da.

Contributory Secondary

(Duration) 17 yrs. 17 mos. 17 da.(Signed) J. H. Steiner M. D.Nov 17, 1930 (Address) Harford Co. Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 17 yrs. 17 mos. 17 da. In the State 17 yrs. 17 mos. 17 da.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Bahus CemeteryNov. 18, 1930

## 20 UNDERTAKER

## ADDRESS

Henry TarringtonCherden Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 6 1933

BUREAU



MARGIN RESERVED FOR RECORDING  
WRITE HERE, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			6500 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			Registration Dist. No. <u>181</u>	
Village or City <u>Aberdeen, Md</u> (No. ....)			St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>William T. Curry</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)		
6 DATE OF BIRTH <u>Sept. 23</u> , 19 <u>23</u> (Month) (Day) (Year)				
7 AGE <u>5</u> yrs. <u>3</u> mos. <u>13</u> ds. or min. If LESS than 1 day hrs. min.				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry business, or establishment in which employed or (employer)				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
PARENTS	10 NAME OF FATHER <u>Frank D. Curry</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u>			
	12 MAIDEN NAME OF MOTHER <u>Jane Todd</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE <u>F. D. Curry</u> (Informant) <u>Aberdeen, Md</u> (Address)				
15 Filed <u>Jan 27</u> 19 <u>23</u> <u>W. H. McMichael</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Jan. 6th/30</u> , 19 <u>23</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan. 4th/30</u> 19 <u>23</u> to <u>Jan. 6th/30</u> 19 <u>23</u> , that I last saw him alive on <u>Jan. 6th/30</u> 19 <u>23</u> , and that death occurred on the date stated above, at <u>3.30 P. m.</u> The CAUSE OF DEATH * was as follows: <u>Scarlet fever-anaphylaxis</u> <u>following administration of</u> <u>scarlet fever anti-toxin</u> <u>Respiratory paralysis</u> Contributory Secondary (Duration) yrs. mos. ds. 3 (Signed) <u>T. P. Thompson</u> M. D. <u>Jan 6th 1923</u> (Address) <u>Aberdeen, Md</u> *State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Grove Cemetery</u>				DATE OF BURIAL <u>Jan. 7/30</u> , 19 <u>23</u>
20 UNDERTAKER <u>Pennington &amp; Son</u>				ADDRESS <u>Havre de Grace</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Solomon, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer retired 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Broncho pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

FEB 8 1930  
BUREAU V. S.



<sup>1</sup> PLACE OF DEATH  
County Harford

09321

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City Rocks (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Jane Roberta Curtis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Infant

6 DATE OF BIRTH Aug 18 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Rocks, Md

10 NAME OF FATHER Ernest G. Curtis

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Isabelle Green

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Green  
(Address) Rocks, Md

<sup>5</sup> Filed Aug 19 1930 NE Richardson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 18 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 18 1930 to Aug 18 1930.

that I last saw him alive on \_\_\_\_\_, 1930.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Still-born (6 mo)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Willard P. Hudson M. D.  
Aug 19 1930 (Address) Forest Hill Md

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Chestnut Grove Cem DATE OF BURIAL Aug 19 1930

<sup>20</sup> UNDERTAKER Ernest Curtis ADDRESS Rocks



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archibed, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "labore," "Foreman," "Manager," "Teacher," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train accident; Revolver wound of head—homicide, Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little care is essential and must be obtained before the certificate is permanently filed.

SEP 6 1908  
BUREAU V. 3



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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1 PLACE OF DEATH  
County Harford

Aberdeen Proving Ground  
Village or City (No. ....)

2 FULL NAME HELEN HOYT DANIELS

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH August 9, 1897  
(Month) (Day) (Year)

7 AGE 32 yrs. 6 mos. 1 ds. or 1 day 1 hrs. 1 min.?  
If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) Housework

9 BIRTHPLACE (State or country) Burlington, Vermont

10 NAME OF FATHER Edward V. Hoyt

11 BIRTHPLACE OF FATHER (State or country) St Albans, Vermont

12 MAIDEN NAME OF MOTHER Violet Underwood

13 BIRTHPLACE OF MOTHER (State or Country) Burlington, Vermont

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert W. Daniels

(Address) Aberdeen Proving Ground, Md.

15 Feb 11 19230 B. B. Michael  
Filed Registrar

01725 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. .... Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 10th, 1930  
February (Month) 10 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from February 3, 1930 to February 10, 1930, that I last saw her alive on February 9, 1930, and that death occurred on the date stated above, at 7.10 A.m.  
The CAUSE OF DEATH \* was as follows:  
Lobar Pneumonia

Contributory  
Secondary

None

(Duration) 0 yrs. 0 mos. 8 ds.  
(Signed) George J. Schirch, Major, M.C. M. D.  
Feb 11 1930 (Address) Aberdeen Proving Ground, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 5 mos. 20 ds. In the State 2 yrs. 5 mos. 20 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Burlington, Vermont

19 PLACE OF BURIAL OR REMOVAL

Burlington, Vermont

DATE OF BURIAL

Feb. 13, 1930

20 UNDERTAKER

Henry Tarring & Sons

ADDRESS

Aberdeen, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Devility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1930  
BUREAU OF



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Whiteford (No. \_\_\_\_\_)2 FULL NAME Henrietta M. Daughlton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) \_\_\_\_\_

6 DATE OF BIRTH March 27, 1930  
(Month) (Day) (Year)

7 AGE 10 hrs If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. 2 ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Whiteford Md

10 NAME OF FATHER Henry E. Daughlton

11 BIRTHPLACE OF FATHER (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Martha Smith

13 BIRTHPLACE OF MOTHER (State or Country) Texas

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry E. Daughlton(Address) Whiteford Md

15 Filed March 31, 1930 M. J. Snarell  
Registrar

03019

161-a

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 184

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 30<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from at birth 1930 to \_\_\_\_\_, 192\_\_\_\_,

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 192\_\_\_\_,

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH \* was as follows:

Premature birthContributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) N. E. Arthur M. D.

March 31, 1930 (Address) Carding Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt. Olivet Cem. March 31, 1930

20 UNDERTAKER ADDRESS

S. W. Holden Della Pa.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation, whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, keloids*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 8 1930

BUREAU



MARGIN RESERVED FOR BLOODING  
WRITE INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Hartford

03480

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 184Village or City Pylesville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Henry Arthur Daugherty

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)6 DATE OF BIRTH March 27, 1937  
(Month) (Day) (Year)7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds. or \_\_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Pythianville Md10 NAME OF FATHER Henry E. Daugherty11 BIRTHPLACE OF FATHER (State or country) Pythianville Md12 MAIDEN NAME OF MOTHER M. L. Smith13 BIRTHPLACE OF MOTHER (State or Country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry E. Daugherty(Address) Pythianville Md15 Filed April 11, 1938 H. J. McHale  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 31, 1937  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from at birth to \_\_\_\_\_, 192\_\_\_\_.that I last saw him alive on March 29, 1938,and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH \* was as follows:

Perinatal asphyxia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. E. Daugherty M. D.April 11, 1938 (Address) Cardiff Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Oliver Cem. March 31, 1938

20 UNDERTAKER

ADDRESS

Henry E. Daugherty



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only, not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data, if essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 6 1900



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

Village or City

Pylesville

(No. ....)

St. ....

Ward) ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Robert James Daughton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

April May 8  
May 25, 1930  
(Month) (Day) (Year)

7 AGE

5 yrs. 17 mos. 17 ds. or min. ?  
If LESS than 1 day .... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Samuel J. Daughton

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Hilditch

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel J. Daughton

(Address)

Pylesville Md.

15

Filed

Oct 25 1930 J. S. Morrish

Registrar

12494

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

113

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Oct 18 1930, to Oct 25, 1930.

that I last saw him alive on Oct 24, 1930.

and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH was as follows:

Cholera Infantum

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... da.

(Signed) Vernon J. Williamson M.D.

Oct 21, 1930 (Address) Cardiff Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .... yrs. .... mos. .... da. In the State, .... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Marys Cem. Oct 25, 1930

20 UNDERTAKER

ADDRESS

John L. Morris Bella Pa.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plasterer*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *House-keeper*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Turned* (retired) (e. g.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Toxic"); *Typhoid fever* (never report "Typhoid pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

*Lat. J. Smith Chicago, Ill.*  
*Aug. 5, 1930*

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Mastitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 days; *Bronchopneumonia* (secondary), 10 days. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Eczema," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Wetness," etc., when a definite disease can be ascertained or the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, STUPIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reveler wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture* of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

In this certificate is included over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data essential and must be obtained before the certificate is permanently filed.

NOV 6 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

Village or City

Burlin

(No. —)

St. — Ward —

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Eliza V. Way

Registration Dist. No. 184

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Widow

6 DATE OF BIRTH

July 4, 1860

(Month)

(Day)

(Year)

7 AGE

69 yrs. 8 mos. 20 ds.

If LESS than

1 day \_\_\_ hrs.

or \_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Housework

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Andrew Banister

11 BIRTHPLACE OF FATHER

(State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Eliza J. Ward

13 BIRTHPLACE OF MOTHER

(State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Min Etta Way

(Address)

Burlington, Md.

15

Filed

March 28, 1920

Registrar

03020

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 28, 1920

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

March 20, 1920, to March 28, 1920

that I last saw her alive on March 27, 1920

and that death occurred on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH \* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 8 ds.

Contributory  
Secondary

La grippe

(Duration) yrs. mos. 10 ds.

(Signed) H. P. S. Surgeon M. D.

3-28-1920 (Address) Burlington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burlington, Md.

March 28, 1920

20 UNDERTAKER

ADDRESS

H. S. Bailey Burlington



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Whiteford (No. \_\_\_\_\_)

2 FULL NAME Chaakley B Dempsey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 12 (Month) 27 (Day) 1870 (Year)

7 AGE 59 yrs. 1 mos. 10 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Cecil County Md

10 NAME OF FATHER John Dempsey

11 BIRTHPLACE OF FATHER (State or country) Cecil County Md

12 MAIDEN NAME OF MOTHER Laral Gray Dempsey

13 BIRTHPLACE OF MOTHER (State or Country) Cecil County Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Chaakley Dempsey

(Address) Whiteford Md

15 Filed Feb 11 1923 J. S. McNabb Registrar

01726

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 8 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 6 1930 to Feb 8 1930, that I last saw him alive on February 8, 1930, and that death occurred on the date stated above, at 2:30 P m. The CAUSE OF DEATH \* was as follows:

Acute nephritis

(Duration) yrs. mos. 3 ds.

Contributory Chronic nephritis  
Secondary Artificial Glyster

(Signed) J. S. McNabb M. D.  
Feb 9 1930 (Address) Cardiff Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Statenville County Feb 11, 1930

20 UNDERTAKER ADDRESS

John E. Norris Della Pa

If more blanks are needed, address State Registrar, 56 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired, 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid, Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

MAR 6 1936

BUREAU V. B.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BUILDING  
WRITE PENNY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Harford

09322 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City Bel Air (No. \_\_\_\_\_) St.: \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Clara J. Densby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Sept. 1, 1878  
(Month) (Day) (Year)

7 AGE 52 yrs. 11 mos. 30 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Edward Webster

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Chice Bond

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Gilbert Densby  
(Address) Bel Air

15 Filed Sept 2 1930 N.E. Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 31, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 30, 1930 to Aug 30, 1930  
that I last saw her alive on \_\_\_\_\_, 192\_\_\_\_,

and that death occurred on the date stated above, at 3:30 P.M.  
The CAUSE OF DEATH \* was as follows:  
Myocarditis

(Duration) 5 yrs. 5 mos. 12 ds.  
Contributory Secondary Terminal pneumonia

(Signed) Dr. H. H. Hopkins M. D.  
Sept 7, 1930 (Address) Bel Air

State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Union M.C. Cemetery DATE OF BURIAL Sept 3, 1930

20 UNDERTAKER Henry Tarrington ADDRESS Chardon Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

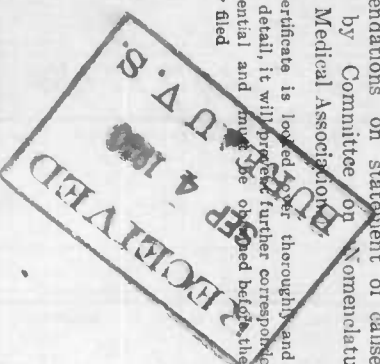
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly, and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed





N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

10466

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 183

Village or City

Rocks Md.

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Alice Mildred De Voe

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Aug 24, 1928

(Month)

(Day)

(Year)

7 AGE

2 yrs. 1 mos. 3 ds.

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work \_\_\_\_\_(b) General nature of industry  
business, or establishment in  
which employed or (employer) \_\_\_\_\_9 BIRTHPLACE  
(State or country)

Maryland

10 NAME OF  
FATHER

Rosa H. De Voe

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md.

12 MAIDEN NAME  
OF MOTHER

Emma Moore

13 BIRTHPLACE  
OF MOTHER  
(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Emma De Voe

(Address)

Rocks Md.

15 Filed

Sept 29 1933 Thomas P. Brown

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 28, 1933

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Sept 20 1933 to Sept 28 1933

that I last saw him alive on Sept 28 1933,

and that death occurred on the date stated above, at 110 m.

The CAUSE OF DEATH \* was as follows:

Enteritis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Charles W. Brown M. D.

Sept 19 1933 (Address) Rocks Md.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place  
of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.In the  
State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

(Crosby De Voe) Sept 30, 1933

20 UNDERTAKER

ADDRESS

Cooptown Am. Doyleville

md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 7 1930

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WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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<sup>1</sup> PLACE OF DEATH  
County St. arford

Village or Near Bully (No. —)

<sup>2</sup> FULL NAME Katherine M. Wick

08079 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 ~~SINGLE~~ Married  
~~MARRIED~~  
~~WIDOWED~~  
~~OR DIVORCED~~  
(Write the word)

6 DATE OF BIRTH July 8, 1877  
(Month) (Day) (Year)

7 AGE 59 yrs. 0 mos. 11 ds. IF LESS than  
1 day \_\_\_ hrs. or \_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Newton McCourtney

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Adelia Thomas

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. C. J. Wick

(Address) Street, Md. R.F. 20

15 Filed July 20 1930 M. N. Kirk  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 19, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 10, 1929 to July 17, 1930  
that I last saw her alive on July 17, 1930

and that death occurred on the date stated above, at 8:30 P.m.  
The CAUSE OF DEATH \* was as follows:

Intestinal Carcinoma

(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) H. E. Arthur M. D.

July 20, 1930 (Address) Candiff, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Emory Cem., July 22, 1930

20 UNDERTAKER ADDRESS

H. S. Bailey, Warlington

Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE

ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

04376

74-a

St.: Ward)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at  
The CAUSE OF DEATH \* was as follows:Contributory  
Secondary

(Signed) M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1931  
BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Dublin (No. —)

2 FULL NAME Margawitte Horsey

04377 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St. — Ward — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, Single  
~~MARRIED~~  
~~WIDOWED~~  
~~OR DIVORCED~~  
(Write the word)

6 DATE OF BIRTH April 10 1928  
(Month) (Day) (Year)

7 AGE 2 yrs. 0 mos. 0 ds. or — min.?  
If LESS than 1 day, hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) None

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Geo. Horsey

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Levins

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Horsey  
(Address) Harlington Md.

15 Filed April 10 1930 M. W. Kirk -  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 10 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 5 1930 to April 10 1930  
that I last saw her alive on April 9 1930  
and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH \* was as follows:  
Bronchial Pneumonia

Contributory Secondary Whooping Cough  
(Duration) yrs. 15 ds.

(Signed) H. H. Hoagwood M. D.  
April 10 1930 (Address) Harlington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hosanna Cem DATE OF BURIAL April 12 1930

20 UNDERTAKER H. S. Bailey ADDRESS Harlington Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Peeler," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., (Tubercle, Scrophulous, etc., of . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Mucosae; Whooping cough; Chronic indurated heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Cema," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling tree—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A.1. the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 11 1930



MARGIN RESERVED FOR BUILDING  
WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

66763

STATE OF MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH  
County Harford

Registration Dist. No. 185

Village or City Harford (No. 810 Adams St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby (Brown) Dorsey

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>June 1</u> , 192 <u>30</u> (Month) (Day) (Year)	17 I HEREBY CERTIFY, That I attended the deceased from <u>June 1<sup>st</sup></u> , 192 <u>30</u> to <u>June 1<sup>st</sup></u> , 192 <u>30</u> . that I last saw him <u>alive</u> on <u>June 1<sup>st</sup></u> , 192 <u>30</u> , and that death occurred on the date stated above, at <u>8 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Still Born</u> (Duration) <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.
6 DATE OF BIRTH <u>June 1</u> , 192 <u>30</u> (Month) (Day) (Year)	7 AGE <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. or <u>      </u> min.?	8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>      </u>	Contributory Secondary <u>      </u> (Duration) <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. (Signed) <u>F. S. Skew</u> M. D. <u>6-2</u> 192 <u>30</u> (Address) <u>Harford, Md.</u>	
9 BIRTHPLACE (State or country) <u>Md.</u>	10 NAME OF FATHER <u>John Brown</u>	11 BIRTHPLACE OF FATHER <u>Md.</u>	12 MAIDEN NAME OF MOTHER <u>Henriette Dorsey</u>	13 BIRTHPLACE OF MOTHER <u>Md.</u>
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Henriette Dorsey</u> (Address) <u>810 Adams St.</u>				
15 Filed <u>June 2</u> , 192 <u>30</u> <u>Chas. J. Fuley, M.D.</u> Registrar				
19 PLACE OF BURIAL OR REMOVAL <u>St. James</u>			DATE OF BURIAL <u>June 2</u> , 192 <u>30</u>	
20 UNDERTAKER <u>Madison Mitchell</u>			ADDRESS <u>W. S. No. 1</u>	

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  
At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

JUN 6 1930  
BUREAU U. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Chesden (No. ....)

2 FULL NAME Edward D. Douglas

06764 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH June 8, 1930  
(Month) (Day) (Year)

7 AGE Sill-born If LESS than 1 day 0 hrs. 0 yrs. 0 mos. 0 ds. or 0 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER D. G. Douglas

11 BIRTHPLACE OF FATHER (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ethel Woodie

13 BIRTHPLACE OF MOTHER (State or Country) North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. D. G. Douglas

(Address) Chesden Md

15 Filed June 9 1930 Dr. Michael  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 8, 1930 to June 8, 1930, that I last saw him alive on ....., 192....

and that death occurred on the date stated above, at ..... m. The CAUSE OF DEATH \* was as follows:

Born dead  
full term

Contributory Secondary Contracted Pelvis of mother  
(Duration) yrs. mos. ds.

(Signed) Chas. Knuts M. D.  
June 8, 1930 (Address) Chesden Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wm. Zion Cemetery June 9, 1930

20 UNDERTAKER ADDRESS

Henry Tarrington Chesden Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 1 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. ACE should be stated-EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harpur

90  
WITHIN CORPORATE LIMITS OF

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Harre de Grace Md

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Jacob Dixin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Sept 9, 1861  
(Month) (Day) (Year)

7 AGE 68 If LESS than 1 day \_\_\_\_ hrs. 1 day \_\_\_\_ hrs. 29 yrs. 10 mos. 15 ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work General Store  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER William Dixin

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Gordon

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grover Davis

(Address) Bel Air Md

15 Filed July 26, 1930 Charles J. Day, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 19, 1930 to July 24, 1930.

that I last saw him alive on July 24, 1930.

and that death occurred on the date stated above, at 8:30 P m.

The CAUSE OF DEATH \* was as follows:

Cardiac Decompensation  
Enterocolitis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) [Signature] M. D.

7-24 1930. (Address) Harre de Grace Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

MT Zion July 27, 1930

20 UNDERTAKER ADDRESS

Dean & Foster Bel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BUILDING

WRITE WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Street (No. \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 184

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME unnamed Doyle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,         
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

May 3, 1930  
(Month) (Day) (Year)

7 AGE

2  
yrs. mos. ds. or min.?If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Harford Co. Md.

10 NAME OF

FATHER

Jacob Kenneth Doyle

11 BIRTHPLACE

OF FATHER

(State or country)

Harford Co. Md.

12 MAIDEN NAME

OF MOTHER

Carol B. Miller

13 BIRTHPLACE

OF MOTHER

(State or Country)

Harford Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Kenneth Doyle  
Street Md.

15

Filed May 31 1930 by J. J. McNabb  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 3, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended the deceased ~~from~~at birth to \_\_\_\_\_, 192\_\_\_\_,that I last saw him alive on \_\_\_\_\_, 192\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Stillborn

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. E. Arthur M. D.

192\_\_\_\_ (Address)

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Omory Cem.May 3rd 1930

20 UNDERTAKER

ADDRESS

Jacob Kenneth Doyle Street Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford Co</u> Village or City <u>Near Norrisville</u> No. _____			10467 STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>183</u>		
2 FULL NAME <u>Benjamin G Duncan</u>			St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>Sept 15</u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Sept 10</u> , 18 <u>30</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 15</u> , 19 <u>30</u> to <u>Sept 15</u> , 19 <u>30</u> , that I last saw him alive on <u>Sept 15</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>9:30</u> m.		
7 AGE <u>60</u> yrs. - <u>5</u> mos. <u>5</u> ds. or min.?			The CAUSE OF DEATH * was as follows: <u>Cerebral Hemorrhage</u> (Duration) _____ yrs. _____ mos. _____ ds.		
OCCUPATION (a) Trade, profession or particular kind of work. <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.		
9 BIRTHPLACE (State or country) <u>Ind</u>			(Signed) <u>Crans</u> M. D. <u>Sept 15</u> , 19 <u>30</u> (Address) <u>Stewartstown Pa</u>		
10 NAME OF FATHER <u>Andrew Duncan</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
12 MAIDEN NAME OF MOTHER <u>Anna Huston</u>			Where was disease contracted, if not at place of death? _____ Former or usual residence _____		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ind</u>			19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Robert Duncan</u> (Address) <u>Farm near Pa</u>			20 UNDERTAKER <u>J. H. Hobbs</u> ADDRESS <u>Farm near Pa</u>		
15 Filed <u>Sept 17</u> , 19 <u>30</u> <u>Thomas R Brown</u> Registrar					

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDER  
WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Harford*

WITHIN CORPORATE LIMITS OF

15054

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *185*

Village or City

*Harredesville* (No. *4*)

St.:

Ward:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*James C. Duff*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female white*

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Widow*

6 DATE OF BIRTH

*January 19, 1843*  
(Month) (Day) (Year)

7 AGE

*87 yrs. 10 mos. 20 ds.* or *min.?*  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Housework.*

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Maryland.*

10 NAME OF FATHER

*J. A. Elliott*

11 BIRTHPLACE OF FATHER

(State or country)

*Maryland.*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs. Geo. Walker,*

(Address)

*Harredesville, Md.*

15 Filed

*Dec. 12 1930* *Chas. J. Foley, M.D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Dec 10, 1930*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*Dec 1, 1930* to *Dec 10, 1930*that I last saw her alive on *Dec 10 1930*

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

*Arterio-sclerosis, congestive**Heart failure*(Duration) *6* yrs. *6* mos. *6* ds.Contributory  
Secondary*Exhaustion*(Duration) *2* yrs. *2* mos. *2* ds.

(Signed)

*Charles J. Foley, M.D.**12/12/1930* (Address) *Harredesville, Md.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Friendship Cemetery**Dec. 12, 1930*

20 UNDERTAKER

ADDRESS

*Pennington & Son**Harredesville, Md.*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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(a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 3 1931

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lelæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified--Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS OF

10468

(159.8)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Harford

(No.)

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Infant Rufree

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Sept. 1, 1930

(Month)

(Day)

(Year)

7 AGE

3 yrs. 3 mos. 3 ds.

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Sept. 3, 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 3, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept. 1, 1930 to Sept. 3, 1930

that I last saw him alive on Sept. 3, 1930

and that death occurred on the date stated above, at 2 p.m.

The CAUSE OF DEATH \* was as follows:

Imperfect Fetal Development (Placental Foramen Ovale) (Duration) yrs. mos. ds.

Contributory Secondary

(Signed) J. J. Magraw M. D. 9/30/30 (Address) Berwyn

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cokesbury Ave. Sept. 5, 1930

20 UNDERTAKER

ADDRESS

Lee A. Patterson Berwyn



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dag laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

RECEIVED

BUREAU



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than

1 day hrs.

yrs. mos. ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory Secondary

(Signed) M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

BUREAU



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford

06765

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 182

(129)

Village or City Bel Air (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Margaret Jane Scoff

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Female 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

 6 DATE OF BIRTH Nov - 1952  
(Month) (Day) (Year)

 7 AGE 77 yrs. 7 mos. - ds. or - min. If LESS than 1 day \_\_\_\_ hrs.

 8 OCCUPATION (a) Trade, profession or particular kind of work House Keeping  
(b) General nature of industry, business, or establishment in which employed or (employer)

 9 BIRTHPLACE (State or country) Ind

 10 NAME OF FATHER Herman Pyle

 11 BIRTHPLACE OF FATHER (State or country) Ind.

 12 MAIDEN NAME OF MOTHER Jane Puff.

 13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. E. Gross

(Address) \_\_\_\_\_

 15 Filed June 9 1930 W. E. Richardson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH June 8, 1930  
(Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from May 15, 1930 to June 8, 1930, that I last saw her alive on June 7, 1930, and that death occurred on the date stated above, at 1:00 A. M.

The CAUSE OF DEATH \* was as follows:

Uremia, Terminating Ch  
glomerular nephritis  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.
Contributory  
Secondary
 (Signed) Willard B. Hudson M. D.  
June 9, 1930 (Address) Forest Hill Ind

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ind Labor Cem June 10 1930

 20 UNDERTAKER Hornbarger & Co. Benson ADDRESS \_\_\_\_\_



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysphtheria* (avoid use of "Croup"); "Typhoid fever (never report "Typhoid Pneumonia"); *Scarlet pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

1929  
7/23  
52



N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			WITHIN CORPORATE LIMITS OF 04378		STATE OF MARYLAND	
County <u>Harford</u>			(31)		CERTIFICATE OF DEATH	
Village or City <u>Hd Grace</u> (No. _____)			St. _____		Ward _____	
2 FULL NAME <u>J. Oliver Edmondson</u>			Registration Dist. No. <u>185</u>			
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR-DIVORCED <u>widow</u> (Write the word)				
6 DATE OF BIRTH <u>May 4</u> , 18 <u>55</u> (Month) (Day) (Year)						
7 AGE <u>74</u> yrs. <u>11</u> mos. <u>21</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Genl. Supt.</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Western Union Tel.</u>						
9 BIRTHPLACE (State or country) <u>Maryland</u>						
10 NAME OF FATHER <u>James W. Edmondson</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>						
12 MAIDEN NAME OF MOTHER <u>Mary Brooke</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Walter Edmondson</u> (Address) <u>Harre de Grace, Md.</u>						
15 Filed <u>Apr. 29</u> , 19 <u>30</u> <u>Chas. J. Foley, M.D.</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Apr 26<sup>th</sup></u> , 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Apr 26<sup>th</sup></u> , 19 <u>30</u> to <u>Apr 26<sup>th</sup></u> , 19 <u>30</u> , that I last saw him alive on <u>Apr 26<sup>th</sup></u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>11:55 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Pulmonary tuberculosis</u>						
Contributory Secondary <u>Tuberculosis</u> (Duration) <u>5</u> yrs. <u>0</u> mos. <u>0</u> ds.						
(Signed) <u>J. L. Hopson</u> M. D. <u>Apr 28</u> , 19 <u>30</u> (Address) <u>Harre de Grace, Md.</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Angel Hill Cem.</u>				DATE OF BURIAL <u>Apr. 29, 1930</u>		
20 UNDERTAKER <u>Perumington Son</u>				ADDRESS <u>Hd Grace, Md.</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . [name origin]; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicæmia*, "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 5 1930  
BUREAU OF



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1 PLACE OF DEATH  
County Harford

Village or City Emmorton (No. \_\_\_\_\_)

2 FULL NAME Baby Edwards

10470 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, ~~MARRIED,~~ WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Sept 6, 1930  
(Month) (Day) (Year)

7 AGE Stillborn If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

OCCUPATION

(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed or (employer) Stillborn

9 BIRTHPLACE (State or country) Harford Co., Md

10 NAME OF FATHER Gus Edward

11 BIRTHPLACE OF FATHER (State or country) N.C.

12 MAIDEN NAME OF MOTHER Rosie Barker

13 BIRTHPLACE OF MOTHER (State or Country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father

(Address) Emmorton

15 Filed Sept 6 1930 N E Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 6, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Stillborn 1930 to \_\_\_\_\_, 1930, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 1930,

and that death occurred on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH \* was as follows:

Stillborn

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) P. B. Hopkins M. D.  
Sept 6, 1930 (Address) Bel Air, Md

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Emmorton M.E. Cem DATE OF BURIAL Sept 6, 1930

20 UNDERTAKER Father Gus Edwards ADDRESS Emmorton



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
OCT 7 1930



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
1 PLACE OF DEATH County <u>Harford</u>			STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>181</u>	
Village or City <u>Perryman</u> (No. _____) St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)				
2 FULL NAME <u>Norman L. Elliott</u>				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>August 13, 1920</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>May 6, 1980</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Aug 8, 1920</u> to <u>Aug 13, 1920</u> that I last saw him alive on <u>Aug 13, 1920</u> and that death occurred on the date stated above, at <u>6:00 p.m.</u> The CAUSE OF DEATH* was as follows: <u>Dysentery</u>	
7 AGE _____ yrs. <u>3</u> mos. <u>11</u> ds. or _____ min.?			Contributory Secondary <u>Exhaustion</u>	
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry business, or establishment in which employed or (employer) _____			(Duration) _____ yrs. _____ mos. _____ ds.	
9 BIRTHPLACE (State or country) <u>Maryland</u>			(Signed) <u>F. M. Skene</u> M. D. <u>Aug 14, 1920</u> (Address) <u>Haverhill</u>	
PARENTS	10 NAME OF FATHER <u>John W. Elliott</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	12 MAIDEN NAME OF MOTHER <u>Carrington</u>		Where was disease contracted, if not at place of death? _____ Former or usual residence _____	
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>		19 PLACE OF BURIAL OR REMOVAL <u>Spesutia Cemetery</u> DATE OF BURIAL <u>Aug 15, 1920</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. John W. Elliott</u> (Address) <u>Perryman Md</u>			20 UNDERTAKER <u>Henry Tarrington Sons</u> ADDRESS <u>Chesden Md</u>	
15 Filed <u>Aug 15, 1920</u> Registrar <u>O. H. H. H.</u>				



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coul mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Corcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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SEP 4 1930  
BUREAU V 8



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1 PLACE OF DEATH			05631		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			90		Registration Dist. No. <u>181</u>	
Village or City <u>Harrods Grace, P. F. D.</u>			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John J. Elsner</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, OR DIVORCED (Write the word) <u>Single</u>				
6 DATE OF BIRTH <u>October 29, 1859</u> (Month) (Day) (Year)						
7 AGE <u>70 yrs. 6 mos. - ds.</u> If LESS than 1 day ____ hrs. or ____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired machinist</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Rtd for 10 yrs.</u>						
9 BIRTHPLACE (State or country) <u>Ohio</u>						
PARENTS	10 NAME OF FATHER <u>John Elsner</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>					
	12 MAIDEN NAME OF MOTHER <u>Christiana Raff</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>Harry H. Elsner</u>						
(Address) <u>Harrods Grace, P. F. D.</u>						
15 Filed <u>May 17, 1920</u> <u>Harrods Grace, P. F. D.</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>May 15, 1920</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 15, 1920</u> to <u>May 15, 1920</u> , that I last saw him alive on _____, 1920, and that death occurred on the date stated above, at <u>4:50 P. M.</u>						
The CAUSE OF DEATH * was as follows: <u>Hyperostotic Prostate</u> <u>Acute Prostatitis</u> <u>Metastatic Stenosis</u> (Duration) ____ yrs. <u>7</u> mos. ____ ds.						
Contributory Secondary <u>Hyperostotic Prostate</u> (Duration) ____ yrs. ____ mos. <u>3</u> ds.						
(Signed) <u>Charles J. Foley</u> M. D. <u>5/16</u> 1920 (Address) <u>Harrods Grace, P. F. D.</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)						
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.						
Where was disease contracted, if not at place of death? _____						
Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Lutheran Cemetery</u>						DATE OF BURIAL <u>May 17, 1920</u>
20 UNDERTAKER <u>W. J. Tarrington &amp; Sons</u>						ADDRESS <u>Aberdeen, Md.</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Imanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *A accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1918

BUREAU



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## 1 PLACE OF DEATH

County

*Harford*

Village or City

*Rocks*

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *182*

## 2 FULL NAME

*William A Ely*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*married*

6 DATE OF BIRTH

*July 3, 1869*  
(Month) (Day) (Year)

7 AGE

*70 yrs. 8 mos. 4 ds.*  
If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Farmer*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*md*

10 NAME OF FATHER

*John Ely*

11 BIRTHPLACE OF FATHER

(State or country)

*md*

12 MAIDEN NAME OF MOTHER

*Hanna Tucker*

13 BIRTHPLACE OF MOTHER

(State or Country)

*md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Miss Georgianna W. Ely*

(Address)

*Sharon*

15 Filed

*Mar 8 1930*  
*John E. Richardson*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*March 7, 1930*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *Jan 1, 1929* to *March 5, 1930*that I last saw him alive on *March 5, 1930*and that death occurred on the date stated above, at *4 10 PM*

The CAUSE OF DEATH \* was as follows:

*Arterio-sclerosis  
hypertension + cancer of  
stomach*  
(Duration) yrs. mos. ds.Contributory  
Secondary(Signed) *H. E. Arthur* M. D.

192. (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Fork ME.* *Mar 10, 1930*

20 UNDERTAKER

ADDRESS

*Dean & Foster* *Bolton md*



20

## REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 5 1930

BUREAU



MARGIN RESERVED FOR BINDING

WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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<sup>1</sup> PLACE OF DEATH  
County Harford

6501

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

Village or City Aberdeen (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup>FULL NAME Charles G. Eustace

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>October 19, 1911</u> (Month) (Day) (Year)		
7 AGE <u>18</u> yrs. <u>2</u> mos. <u>17</u> ds. or min.?		
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)		
9 BIRTHPLACE (State or country) <u>New Jersey</u>		
10 NAME OF FATHER <u>Charles Eustace</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>		
12 MAIDEN NAME OF MOTHER <u>Delia Carey</u>		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ireland</u>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Charles Eustace  
(Address) Aberdeen Md

15 Filed Jan 9 1920 Ch. M. M. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 6, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 5, 1930 to Jan 6, 1930, that I last saw him alive on Jan 6, 1930, and that death occurred on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH \* was as follows:  
Lobar Pneumonia  
(Duration) 2 yrs. 2 mos. 12 ds.  
Contributory Cardiac Failure  
Secondary (Duration) 1/2 yrs. 12 mos. 12 ds.  
(Signed) Charles J. Foley M.D.  
1/8 1930 (Address) Aberdeen Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St Francis

DATE OF BURIAL Jan 9, 1930

20 UNDERTAKER Henry Tarrington

ADDRESS Aberdeen Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Kanawha

Village or City Emmorton (No. \_\_\_\_\_)

2 FULL NAME Lucie Webbain Evans

6502

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 180

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Aug 2, 1861  
(Month) (Day) (Year)

7 AGE 68 yrs. 5 mos. 6 ds. If LESS than 1 day. hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Carpenter  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm. Evans

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Lorrainland

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Lucie Evans

(Address) Edg. Ewood

15 Filed Jan 10 1930 Fred. Harlock Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192... to 192...

that I last saw him alive on 192... m.

and that death occurred on the date stated above, at 9 P. M.  
The CAUSE OF DEATH \* was as follows:

Stroke  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) Charles R. Edg. Ewood M. D.  
Jan 8 1930 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt. Carmel Cemetery DATE OF BURIAL Jan. 10, 1930

20 UNDERTAKER Howard K. McComas ADDRESS Abingdon, d.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical means was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1920  
BUREAU V. S.



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1 PLACE OF DEATH  
County Harford

Village or City Summerton (No. \_\_\_\_\_)

2 FULL NAME Mollie L Evans

13841 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH July 12, 1868  
(Month) (Day) (Year)

7 AGE 67 yrs. 3 mos. 25 ds. or min.? (If LESS than 1 day \_\_\_\_\_ hrs.)

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Mrs. F.W.

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Arthur

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. W. Evans

(Address) Edgewood Md

15 Filed November 7, 1923 Fred. Borlak Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 6, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1928 192 to Nov 6, 1923

that I last saw him alive on Nov 6, 1923

and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH \* was as follows:

Arterio-sclerosis

(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary Cerebral Hemorrhage

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Chas. R. Rott M. D. Nov 7, 1923 (Address) Edgewood Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Int. Canal DATE OF BURIAL Nov 8, 1923

20 UNDERTAKER Howard K. McComa ADDRESS Abingdon Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 3 1920

BUREAU V. S.



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## 1 PLACE OF DEATH

County

Harford

04379

(92)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

182

Village or City

Bel Air Md. (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Harvey Ewing

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

married

6 DATE OF BIRTH

May 29, 1879  
(Month) (Day) (Year)

7 AGE

50  
51 yrs. 10 mos. 18 ds. or min.?IF LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Md

10 NAME OF  
FATHER

Geo. E. M. Ewing

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md

12 MAIDEN NAME  
OF MOTHER

Sallie A. Saltsman

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Harvey Ewing

(Address)

Bel Air Md

15

Filed

Apr 18, 1930

V. E. Chambers  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr. 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

April 15, 1930 to April 17, 1930

that I last saw him live on April 16, 1930

and that death occurred on the date stated above, at 1 P. m.

The CAUSE OF DEATH \* was as follows:

Coronary embolism

(Duration) yrs. mos. 3 ds.

Contributory  
Secondary

Collapse

(Duration) yrs. mos. ds.

(Signed)

Carmel H. Happington  
Apr 15, 1930 (Address) Bel Air, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Zion Cemetery

Apr 19, 1930

20 UNDERTAKER

ADDRESS

Dean J. Tatum

Bel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



1 PLACE OF DEATH

County

05632 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

Village or City Abingdon (No. \_\_\_\_\_)St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

March 21, 1897  
(Month) (Day) (Year)

7 AGE

33 yrs. 1 mos. 28 ds. or \_\_\_\_\_ min.?If LESS than  
1 day \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Philadelphia Pa

10 NAME OF FATHER

Wm E Faler

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Crane

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis E Faler

(Address)

Abingdon Md

15 Filed

May 23, 1930 Fred Morlok  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

192 to 192  
May 20, 1930 at Abingdon Md  
that I last saw the deceased on May 20, 1930 at Abingdon Mdand that death occurred on the date stated above, at Abingdon Md

The CAUSE OF DEATH \* was as follows:

Suicide by firearms,  
size 32 Colt revolver, shot  
self in right temple of her  
head  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary(Signed) Fred Morlok  
May 21, 1930 (Address) Abingdon Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thinty Luthern Cemetery May 23, 1930

20 UNDERTAKER

ADDRESS

Howard K. McComas,Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renovet wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

0503

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 184

Village or City

Mill Green (No. 8th Co. Md.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John W. Harmon

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

Mar. 28, 1865

(Month)

(Day)

(Year)

7 AGE

64 yrs. 9 mos. 3 ds.If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Andrew W. Harmon

11 BIRTHPLACE OF FATHER

(State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Mary A. Brown

13 BIRTHPLACE OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

Jan. 2 1930 M. McKie -  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 2, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
Nov. 19 1929 to Jan. 2 1930that I last saw him alive on Jan. 2 1930and that death occurred on the date stated above, at 12:00 m.

The CAUSE OF DEATH \* was as follows:

Heart disease  
Coronary arteryContributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Charles W. Harmon M. D.Jan. 2 1930 (Address) Harford Co. Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emory Co.Jan. 5, 1930

20 UNDERTAKER

ADDRESS

H. S. Bailey Harlington



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1930

BUREAU



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1 PLACE OF DEATH  
County Harford

Village or City Streett (No. \_\_\_\_\_)

2 FULL NAME Sarah Famous

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Sept. 8, 1847  
(Month) (Day) (Year)

7 AGE 83 yrs. — mos. 13 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retail Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) wife

9 BIRTHPLACE (State or country) Harford Co. Md.

10 NAME OF FATHER James Murphy

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Thornton

13 BIRTHPLACE OF MOTHER (State or Country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Laird  
(Address) Streett Md.

15 Filed Sept-24 1920 N.E. Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 21, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 1920 to Sept 20, 1920, that I last saw her alive on Sept 20, 1920, and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH \* was as follows:  
Organic Heart Disease

Contributory Secondary (Duration) 3 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Charles W. Hammond M. D.  
Sept 22, 1920 (Address) Streett

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Ignace's Cem. DATE OF BURIAL Sept. 24, 1920

20 UNDERTAKER Harburger & Co. ADDRESS Benson Rd.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a)

*Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-potential fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashtemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 7 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Barford

Village or City Near Brown de Grace (No. \_\_\_\_\_)

2 FULL NAME Samuel Fields

13842 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH August 25, 1890  
(Month) (Day) (Year)

7 AGE 40 yrs. 2 mos. 6 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer) Stone Quarry

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mamie Fields, (Wife)  
(Address) Port Deposit

15 Filed Nov 3 1920 Charles J. Foley, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 1<sup>st</sup>, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192 to \_\_\_\_\_ 192,

that I last saw him alive on \_\_\_\_\_ 192,

and that death occurred on the date stated above, at 1:20 m.

The CAUSE OF DEATH \* was as follows:

Compound Fracture of both legs  
laceration of scalp and internal  
hemorrhage

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory due to Automobile accident  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Martin P. Foley Coroner M. D.  
Nov 2<sup>nd</sup> 1920 (Address) Brown de Grace, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cypress Virginia DATE OF BURIAL Nov 4<sup>th</sup>, 1920

20 UNDERTAKER Lee A. Patterson ADDRESS Cherry Hill



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Harford

Village or City Fallston (No. \_\_\_\_\_)

2 FULL NAME Lucy V. Fields

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July 23, 1885  
(Month) (Day) (Year)

7 AGE 45 yrs. 7 mos. 6 ds. If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Bay Wood Va.

10 NAME OF FATHER Geo Halcomb

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER V

13 BIRTHPLACE OF MOTHER (State or Country) V

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. G. Fields

(Address) 13 Baldwin Ind.

15 Filed Nov. 19, 1920 D. E. Chambers  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 17, 1920  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from May 20, 1920 to Nov 10, 1920, that I last saw her alive on " 4, 1920, and that death occurred on the date stated above, at 2:00 p. m. The CAUSE OF DEATH \* was as follows:

Chronic Valvular heart disease  
(Duration) 4 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary \_\_\_\_\_

(Signed) W. H. M. Harrison M. D.  
11/18, 1920 (Address) Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Baltimore DATE OF BURIAL Nov. 19, 1920  
Providence M.P.

20 UNDERTAKER Horning & Goss ADDRESS Benson Ind.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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*Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930  
BUREAU V. S.







# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doyle laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation MEANS OF INJURY taken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931  
BUREAU OF VITAL STATISTICS



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u>		09324		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Aberdeen</u> (No. ....)		(66)		Registration Dist. No. <u>181</u>	
2 FULL NAME <u>Joseph F. Flannigan</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>April 15, 1880</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>Aug 17, 1930</u> (Month) (Day) (Year)			
7 AGE <u>50 yrs. 4 mos. - ds.</u> If LESS than 1 day... hrs. or min.?		17 I HEREBY CERTIFY, That I attended the deceased from <u>12</u> <u>minutes</u> <u>after death</u> <u>192</u> that I last saw him alive on <u>2 P.</u> <u>192</u> and that death occurred on the date stated above, at <u>2 P.</u> <u>m.</u> The CAUSE OF DEATH * was as follows: <u>Chronic Alcapshism</u> (Duration) ... yrs. ... mos. ... ds.			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Day Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer)		Contributory Secondary			
9 BIRTHPLACE (State or country) <u>Lawrence Mass.</u>		(Signed) <u>Chas. H. Krich</u> M. D. <u>Aug 20, 1930</u> (Address) <u>Aberdeen</u>			
10 NAME OF FATHER <u>Michael Flannigan</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.			
12 MAIDEN NAME OF MOTHER <u>Elizabeth Flannigan</u>		Where was disease contracted, if not at place of death? Former or usual residence			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>		19 PLACE OF BURIAL OR REMOVAL <u>Baker Cemetery</u>		DATE OF BURIAL <u>Aug 20, 1930</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. J. C. Brien</u> (Address) <u>10 Eutaw st.</u>		20 UNDERTAKER <u>Henry Harrington</u>		ADDRESS <u>Aberdeen Md</u>	
15 Filed <u>Aug 20, 1930</u> <u>Lawrence Mass</u> <u>O. C. Michaud</u> Registrar					

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto. Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as *Asthenia*, *Anaemia* (merely symptomatic), *"Atrophy"*, *"Collapse"*, *"Coma"*, *"Convulsions"*, *"Debility"* ("Congenital," *"Senile"*, etc.), *"Dropsy"*, *"Exhaustion"*, *"Heart failure"*, *"Haemorrhage"*, *"Inanition"*, *"Marasmus"*, *"Old Age"*, *"Shock"*, *"Uræmia"*, *"Weakness"*, etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as *"PUERPERAL septicæmia"*, *"PUERPERAL peritonitis"*, etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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SEP 4 1930

BUREAU OF



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1 PLACE OF DEATH

County

Village or City

(No.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day... hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Dec 10 1930

1930

O. E. Chambers

Registrar

15056

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1929 to Dec 7, 1930

that I last saw him alive on Dec 4, 1930

and that death occurred on the date stated above, at 11 A. m.

The CAUSE OF DEATH \* was as follows:

Also Sclerotic Emulsion  
Produce Paralysis  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) Chas. R. Richards M. D.  
Dec 10 1930 (Address) Bel Air Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 5 mos. 15 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

County Home

Dec 10, 1930

20 UNDERTAKER

ADDRESS

Deane &amp; Doster

Bel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-pneumonia* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 3 1931

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Village or City

(No. \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~WIFE~~ MARRIEDMARRIED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Aug 22 1930

1930

Bethesda, Md.

B. Knight

Deputy Registrar

20 UNDERTAKER

ADDRESS

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harmony Am

Aug 23, 1930

H &amp; Bailey

Baltimore

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Broncho pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ictæmia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED



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1 PLACE OF DEATH

County

Harford

03022

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Harrells Cross

St.

Ward

(If death occurred in a hospital or institution, give its NAME in full, street and number.)

2 FULL NAME

Mary Emma Frederick

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single

6 DATE OF BIRTH

August 21, 1858

7 AGE

71 yrs. 6 mos. 26 ds. or min.?

If LESS than 1 day.....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Mar. 20, 1930

Chas. J. Foley, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 17, 1930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from Mar 1, 1930 to Mar 17, 1930

that I last saw him alive on Mar 18, 1930

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH \* was as follows:

Chronic Valvular Disease of Heart, Chronic Hypertension

Contributory Secondary

(Duration) yrs. 13 mos. ds.

(Signed) Chas. J. Foley M. D.

3/20/1930 (Address) Perryville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Erin, cem March 22, 1930

20 UNDERTAKER

ADDRESS

Lee G. Patterson Perryville Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

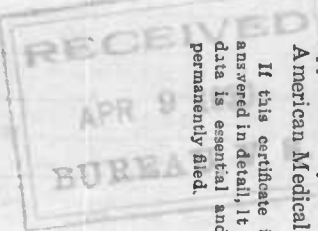
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plaster, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic, valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





**N.B.**--Every item of information should be carefully supplied. ACE should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See instructions on back of certificate. →

1 PLACE OF DEATH  
County Harford

Village or City Chesden (No. \_\_\_\_\_)

2 FULL NAME Evelyn Irene

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH Sept. 7, 1929  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.

OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Norfolk Va.

PARENTS

10 NAME OF FATHER <u>John H. Fruse</u>	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
12 MAIDEN NAME OF MOTHER <u>Frances V. Hopkins</u>	13 BIRTHPLACE OF MOTHER (State or Country) <u>Virginia</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mr. John H. Fruse  
(Address) Chesden Md

15 Filed Nov 24 1929 O B Michael Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 22, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
Nov 21 1920 to Nov 22 1920

that I last saw h er alive on Nov 22, 1923

and that death occurred on the date stated above, at.....m.  
The CAUSE OF DEATH \* was as follows:

Ileo Calitis  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 da.

**Contributory  
Secondary**

(Duration) ..... yrs. .... mos. .... ds.  
(Signed) W. K. Williams M. D.  
Nov 21 1930 (Address) Perryman

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.      In the State.....yrs.....mos.....ds.

Where was disease contracted,  
if not at place of death?.....

Former or  
usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bakers Cemetery	Nov. 25, 1930

20 UNDERTAKER	ADDRESS
Genie Taranto House	Chadron Neb

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

DEC 6 1930

B



MARGIN RESERVED FOR BUREAU OF VITALS, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<p>PLACE OF DEATH County <u>Harford</u></p>		<p>03023 WITHIN CORPORATE LIMITS OF <u>122-B</u></p>		<p>STATE OF MARYLAND CERTIFICATE OF DEATH</p>	
<p>Village or City <u>Oldelsace</u> (No. _____)</p>		<p>St: _____ Ward _____</p>		<p>Registration Dist. No. <u>185</u></p>	
<p>2 FULL NAME <u>Elizabeth F. Feltton</u></p>					
<p>PERSONAL AND STATISTICAL PARTICULARS</p>					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>			
6 DATE OF BIRTH <u>September 6, 1863</u> (Month) (Day) (Year)					
7 AGE <u>66</u> yrs. <u>6</u> mos. <u>3</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>housework</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>John Harrow</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Sarah Lee</u>				
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Mrs. Fred Fadelery</u>					
(Address) <u>Oldelsace, Md.</u>					
15 Filed <u>March 11, 1930</u> by <u>J. Foley, M.D.</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>March 10, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 5, 1929</u> to <u>March 10, 1930</u> , that I last saw her alive on <u>March 10, 1930</u> , and that death occurred on the date stated above, at <u>2:30 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Hypertrophic Cardio</u> <u>7 years</u> (Duration) yrs. mos. ds.					
Contributory Secondary <u>Abstruction Jaundice</u> (Duration) yrs. mos. ds.					
(Signed) <u>F. W. Skinner</u> M. D. <u>3-11-1930</u> (Address) <u>Harris &amp; Sons</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)					
At place of death yrs. mos. ds. In the State yrs. mos. ds.					
Where was disease contracted, if not at place of death?					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Angel Hill Cem.</u>				DATE OF BURIAL <u>March 13, 1930</u>	
20 UNDERTAKER <u>Remington &amp; Sons</u>				ADDRESS <u>Oldelsace</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 5 1930

BUREAU



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PLACE OF DEATH  
County Harford

Village or City Forest Hill (No. \_\_\_\_\_)

2 FULL NAME Ellen Nelson Galbreath

03024

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Sept 17 1874  
(Month) (Day) (Year)

7 AGE 55 yrs. 10 mos. 15 ds. or 1 day 15 hrs. 5 min. If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) Self.

9 BIRTHPLACE (State or country) Harford co md.

10 NAME OF FATHER James W. Galbreath

11 BIRTHPLACE OF FATHER (State or country) Harford co md.

12 MAIDEN NAME OF MOTHER Rebecca C. Robinson

13 BIRTHPLACE OF MOTHER (State or country) Harford co md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Galbreath

(Address) Rocky Mt.

15 Filed Mar 4 1930 W. E. Richardson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 3 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1929 to 1929, 1929.

that I last saw him alive on 9 45 1930.

and that death occurred on the date stated above, at 9 45 A. M.

The CAUSE OF DEATH \* was as follows:

Was treated at Endowment for  
10 years  
Pulmonary Tuberculosis Chronic  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Connel A. Spangman M. D.  
Mar 4 1930 (Address) Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL March 6, 1930

20 UNDERTAKER E. G. King of ADDRESS Sanctiville



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); "Typhoid fever (never report "Typhoid Pneumonia"); *about pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Senile," etc.), "Dropsy," "Debility" ("Congenital," "Senile," etc.), "Convulsions," "Exhaustion," "Heart failure," "Haemorrhage," "Imanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
APR 15 1930.  
BUREAU V. B.



WRITE HERE, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Harford*

04380

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *181*Village or City *Perryman* No. ....

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Mrs. Laura Huse Gallup*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)  
*Widow*

6 DATE OF BIRTH

*January 20, 1850*  
(Month) (Day) (Year)

7 AGE

*80 yrs. 2 mos. - ds. or min.?*  
If LESS than 1 day.....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Baltimore Md*

10 NAME OF FATHER

*John Grapel*

11 BIRTHPLACE OF FATHER

(State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Ann M. Hinder*

13 BIRTHPLACE OF MOTHER

(State or country)

*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs. Parker Mitchell*

(Address)

*Perryman Md*

15

Filed

*Apr 14 1930*  
*O. Michael*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*April 17, 1930*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *January 1927* to *April 17, 1930*, that I last saw *her* alive on *4-17-30*, 19*30*.and that death occurred on the date stated above, at *8:30 P.M.*

The CAUSE OF DEATH \* was as follows:

*General degeneration  
incident to old age  
Anterior sclerosis: ten years' course*  
(Duration) ..... yrs. .... mos. .... ds.Contributory  
Secondary(Signed) *P. H. Otis* M. D.*4-10-30* (Address) *Perryman Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Presbiterian Cemetery**April 19, 1930*

20 UNDERTAKER

ADDRESS

*Henry Taming & Sons*  
*Chesden Md*

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

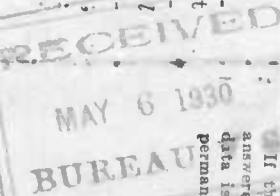
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		05633 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>		Registration Dist. No. <u>185</u>	
Village or City <u>Harford Grace, Md</u>		St. _____ Ward _____	
2 FULL NAME <u>(Jury) Solomos Garasemos</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year)			
7 AGE <u>Abt. 43</u> yrs. .... mos. .... ds. or .... min. ? If LESS than 1 day .... hrs.			
8 OCCUPATION (a) Trade, profession or particular kind of work. <u>Candy</u> (b) General nature of industry, business, or establishment in which employed or (employer). <u>Manufacturer</u>			
9 BIRTHPLACE (State or country) <u>Greece</u>			
PARENTS			
10 NAME OF FATHER <u>Michaelis Solomos</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Greece</u>			
12 MAIDEN NAME OF MOTHER <u>Engelia Tourmist</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Greece</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Harry Vantor</u> (Address) <u>Harford Grace, Md</u>			
15 Filed <u>May 12, 1930</u> <u>Charles J. Foley, M.D.</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 11, 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>April 23, 1930</u> , to <u>May 11, 1930</u> , that I last saw him alive on <u>May 11, 1930</u> , and that death occurred on the date stated above, at <u>11:30 A.M.</u>			
The CAUSE OF DEATH was as follows: <u>Perforated Gastric Ulcer</u> <u>Generalized Peritonitis</u> <u>Broncho Pneumonia</u> (Duration) .... yrs. .... mos. <u>18</u> ds. Contributory <u>Cardiac &amp; Respiratory Failure</u> Secondary (Duration) .... yrs. .... mos. <u>6</u> ds. (Signed) <u>Charles J. Foley</u> M. D. <u>5/12/30</u> (Address) <u>Harford Grace, Md</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds. Where was disease contacted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Baltimore, Md.</u>		DATE OF BURIAL <u>May 13, 1930</u>	
20 UNDERTAKER <u>Cunnington &amp; Son</u>		ADDRESS <u>Harford Grace</u>	



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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*. *Bronchopneumonia*, ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptom or terminal condition, such as "Asphemia," "Anæmia" (merely symptomatic), "Atrophy," "Colicæ," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (If commendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUN 5 1930

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Retroler wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Harford

WITHIN CORPORATE LIMITS OF

15058

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 136Village or City Hamde Grace (No.       ) Hospital       St.        Ward        (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Hamilton G. Giesbert

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH Unknown, 1        (Month) (Day) (Year)7 AGE 39 yrs. — mos. — ds. or — min. If LESS than 1 day — hrs.8 OCCUPATION (a) Trade, profession or particular kind of work Farmer (b) General nature of industry business, or establishment in which employed or (employer) Dairyman9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER William M. Giesbert11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Grace Meier13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hamilton G. Giesbert(Address) Rocks Md15 Filed Dec 4 1930 Charles J. Foley M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 3<sup>d</sup>, 1930 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192that I last saw h        alive on       , 192and that death occurred on the date stated above, at 10 O'clock P.M.

The CAUSE OF DEATH \* was as follows:

Cardiac Decompensation(Duration)        yrs.        mos.        ds.Contributory Acute Alcoholism

Secondary

(Duration)        yrs.        mos.        ds.(Signed) Martin P. Foley "Coroner" M. D. Dec 4<sup>th</sup> 1930 (Address) Hamde Grace, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death        yrs.        mos.        ds. 5 hours In the State        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?

Former or usual residence       19 PLACE OF BURIAL OR REMOVAL Mt. Chert Cm. Fiddick DATE OF BURIAL Dec 6, 193020 UNDERTAKER M. H. Etchison & Son ADDRESS Fiddick Md.



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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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<b>1 PLACE OF DEATH</b> County <u>Harford</u>			15059 WITHIN CORPORATE LIMITS OF			<b>STATE OF MARYLAND</b> <b>CERTIFICATE OF DEATH</b>			Registration Dist. No. <u>185</u>		
Village or City <u>Harre de Grace</u> (No. _____)			St. _____ Ward _____			(If death occurred in a hospital or institution, give its NAME instead of street and number.)					
<b>2 FULL NAME</b> <u>Aurelia Giles</u>											
<b>PERSONAL AND STATISTICAL PARTICULARS</b>											
<b>3 SEX</b> <u>Female</u>		<b>4 COLOR OR RACE</b> <u>colored</u>		<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> <u>widow</u> (Write the word)							
<b>6 DATE OF BIRTH</b> <u>unknown</u>				(Month) _____ (Day) _____ (Year) _____							
<b>7 AGE</b> <u>abt 66 yrs.</u>				(mos.) _____ (ds.) _____ (or min.) _____ If LESS than 1 day _____ hrs.							
<b>8 OCCUPATION</b> (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____				<b>16 DATE OF DEATH</b> <u>Dec 25, 1920</u> (Month) _____ (Day) _____ (Year) _____							
<b>9 BIRTHPLACE</b> (State or country) <u>Maryland</u>				<b>17 I HEREBY CERTIFY, That I attended the deceased from</b> <u>June 1920</u> to <u>Dec 25, 1920</u> that I last saw her alive on <u>Dec 25, 1920</u> and that death occurred on the date stated above, at <u>8 A.M.</u> The CAUSE OF DEATH * was as follows: <u>Arterio Sclerosis</u> <u>Endocarditis</u> (Duration) _____ yrs. _____ mos. _____ ds.							
<b>10 NAME OF FATHER</b> <u>Polonius Brown</u>				Contributory <u>Cardiac Failure</u> Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.							
<b>11 BIRTHPLACE OF FATHER</b> <u>Maryland</u>				(Signed) <u>Charles J. Foley</u> M. D. <u>12/27, 1920</u> (Address) <u>Harre de Grace</u>							
<b>12 MAIDEN NAME OF MOTHER</b> <u>unknown</u>				*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.							
<b>13 BIRTHPLACE OF MOTHER</b> <u>unknown</u>				<b>18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)</b> At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.							
<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b> (Informant) <u>Raymond Giles</u> (Address) <u>Harre de Grace, Md.</u>				Where was disease contracted, if not at place of death? _____ Former or usual residence _____							
<b>15 Filed</b> <u>Dec 27 1920</u> <u>Chas. J. Foley, M.D.</u> Registrar				<b>19 PLACE OF BURIAL OR REMOVAL</b> <u>Union Cemetery</u>				<b>DATE OF BURIAL</b> <u>Dec. 28, 1920</u>			
				<b>20 UNDERTAKER</b> <u>Pennington &amp; Son</u>				<b>ADDRESS</b> <u>Harre de Grace, Md.</u>			



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**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile, etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 3 1931  
BUREAU



MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Harford

03025

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

Village or City Chesden (No. Q. 4-B. #2)

St: \_\_\_\_\_ Ward: \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles H. Golladay

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Sept. 8, 1919  
(Month) (Day) (Year)

7 AGE 5 yrs. 5 mos. 26 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Martin H. Golladay

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna M. Elasewith

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Martin H. Golladay

(Address) Chesden Md. Q. 4-B. #2

15 Filed Oct 3-30 1930 O. Michael Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 28, 1930 to March 4, 1930, that I last saw him alive on Mar 4, 1930

and that death occurred on the date stated above, at 7:50 P.M.

The CAUSE OF DEATH \* was as follows: Gastro Enteritis

(Duration) 0 yrs. 0 mos. 10 ds.

Contributory Secondary

(Signed) Christ Schiote M.D.  
Mar 5, 1930 (Address) Chesden Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Babers Cemetery DATE OF BURIAL March 6, 1930

20 UNDERTAKER Henry Tanning Sons ADDRESS Chesden Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 7 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

Village or City

Edgewood General

## 2 FULL NAME

Emma Aldora Zortach

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH

Jan 14, 1864  
(Month) (Day) (Year)

7 AGE

66 yrs. 2 mos. 21 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

West Ohio

10 NAME OF FATHER

Abey M. C. Zortach

11 BIRTHPLACE OF FATHER (State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Rueck

13 BIRTHPLACE OF MOTHER (State or Country)

Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Randolph Monroe

(Address)

Edgewood Md

15

Filed April 6, 1923 Fred L. Harlock  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 4, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 29, 1922 to Apr 4, 1923

that I last saw him alive on Apr 3, 1923

and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH \* was as follows:

Heart failure

(Duration) 3 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) 30 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

Apr 4, 1923 (Address) Edgewood Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Lincoln Cemetery

DATE OF BURIAL

April 7, 1930

20 UNDERTAKER

Howard K. McComas,

ADDRESS

Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 8 1930  
BUREAU



MARGIN RESERVED FOR BINDING

WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

## 1 PLACE OF DEATH

County

Harford

08081 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

1844

Village or City

Burlington R.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Virginia Lee Gorrell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female  
White

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

July 30

1930

(Month)

(Day)

(Year)

7 AGE

65  
66 yrs.

11 mos.

29 ds.

If LESS than

1 day

hrs.

ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Wardian Lady

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Harford Co Md

10 NAME OF FATHER

Henry S Gorrell

11 BIRTHPLACE OF FATHER

(State or country)

Harford Co Md

12 MAIDEN NAME OF MOTHER

Susanna Brannan

13 BIRTHPLACE OF MOTHER

(State or country)

Harford Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles W Jackson

(Address)

15 Filed

July 30 1930 J. P. McRabb

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 29, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

7:15 p.m. July 27, 1930 to 8:15 p.m. July 28, 1930

that I last saw him alive on July 27, 1930

and that death occurred on the date stated above at 8 a.m.

The CAUSE OF DEATH \* was as follows:

Suicide by drinking  
3 or 4 Carboloid acid

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

A. E. Arthur M. D.  
July 30, 1930 (Address) Card City Md

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brook Coast Cemetery July 31, 1930

20 UNDERTAKER

ADDRESS

John L. Norris Delta Pa

If more blanks are needed, address State Registrar 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Chopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marshus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 6 1910  
BUREAU



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Village or City

(No.

13846 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Nov 2<sup>nd</sup> 1930

Thomas R. Brown

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 1, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Oct 24, 1930 to Nov 1, 1930.

that I last saw her alive on Oct 31, 1930.

and that death occurred on the date stated above, at 17<sup>29</sup> A.M.

The CAUSE OF DEATH was as follows:

Cerebral Thrombosis

Contributory  
Secondary

(Signed) Willard P. Hudson M.D.

Nov 1, 1930 (Address) Forest Hill, Md.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury; and (2) whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents)At place  
of death.... yrs. .... mos. .... da.In the  
State, .... yrs. .... mos. .... da.Where was disease contracted,  
if not at place of death?Former or  
usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Piney Grove Cem.

Nov 3, 1930

20 UNDERTAKER

ADDRESS

Edmundson

Jencks &amp; Sons



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Turner (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (R commendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

In this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK--THIS IS A MARRIAGE RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Rocks R.F.D. (No. \_\_\_\_\_, St. \_\_\_\_\_ Ward \_\_\_\_\_)

2 FULL NAME Adam Grace

06766 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 183

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, married, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH Aug 1877  
(Month) (Day) (Year)

7 AGE 53 yrs. 10 mos. 1 ds. or 1 min. ? If LESS than 1 day.... hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Farmer (b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Tenn.

PARENTS

10 NAME OF FATHER David J. Grace

11 BIRTHPLACE OF FATHER (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Lindia Profit

13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Adam Grace

(Address) Rocks md.

15 Filed June 15 1930 Thomas R. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 18 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 5 1930 to June 18 1930 that I last saw him alive on June 18 1930 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH was as follows:

Sun Stroke (Thrombus Fowl)

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
(Signed) H. E. Arthur M. D.

June 10 1930 (Address) Cardiff Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sanettsville Cem. June 15 1930

20 UNDERTAKER ADDRESS  
Ellen G. Don Sanettsville



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia").

RECEIVED

JUL 3 1930

BUREAU

"unqualified, is indefinite"); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Quinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mastitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mastitis* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WHEN ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Hearford

Village or City

Hillstone Md.

(No.

01727 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

182

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

William H Gray

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Oct 15, 1856

(Month)

(Day)

(Year)

7 AGE

73 yrs. 4 mos. 10 ds.

If LESS than 1 day, hrs. OR min. ?

## OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment to which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

George Gray

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Eloza Bowman

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Fannie Gray

(Address)

Hillstone Md.

15

Filed

Feb 6, 1930 N. E. Richardson

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 8, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb 1929, to Feb 5, 1930

that I last saw him alive on Feb 1, 1930

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH \* was as follows:

Carcinoma Colon

+ Metastasis

(Duration) 2 yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

Orrinell L. Rappaport

Feb 6, 1930 (Address) Hillstone

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

in the

of death yrs. mos. ds.

State, yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rock Run Cemetery Feb 8, 1930

20 UNDERTAKER

ADDRESS

H. G. Walker Forest Hill Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Roadster wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-tions answered in detail, it will prevent further correspond-ence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 5 1920  
BUREAU V. S.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Harford

03026

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

Village or City Chesden (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Robert Green

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH December 7, 1929  
(Month) (Day) (Year)

7 AGE 1 yrs. 3 mos. 3 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION (a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Will Green

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Georganna Mitchell

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Will Green

(Address) Chesden Md

15 Filed March 11, 1930 O. C. Green  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 10, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 8<sup>th</sup> 1930 to March 10, 1930  
that I last saw him alive on March 9<sup>th</sup>, 1930

and that death occurred on the date stated above, at 2:30 p.m.  
The CAUSE OF DEATH \* was as follows:

Whooping Cough

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 14 ds.  
Contributory Secondary Convulsions

(Signed) J. M. Skinner M. D.  
3-10 1930 (Address) Harford Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt. Calvary Cemetery March 11 1930

20 UNDERTAKER ADDRESS

Henry Tarrington Chesden Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Tetanum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930  
BUREAU



WRITE

WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

04382

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

Village or City

Aberdeen P.T.D.

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ann E. Greenland

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
OR DIVORCED  
(Write the word)

Widow

6 DATE OF BIRTH

September 22, 1843

7 AGE

86 yrs. 6 mos. - ds. or min.?

IF LESS than  
1 day... hrs.  
ds. or min.?

OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

George Cullum

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Annale Walker

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Maude T. Greenland

(Address)

Aberdeen P.T.D.

15

Filed

April 16 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 13, 1930

17 I HEREBY CERTIFY, That I attended the deceased from ~~April 31, 1929~~ to April 13, 1930, that I last saw her alive on April 9, 1930.

and that death occurred on the date stated above, at 12:00 p.m.

The CAUSE OF DEATH \* was as follows:

General Debility

Contributory  
Secondary

(Duration) 2 yrs. mos. ds.

(Signed) ~~Dr. Phillips~~ W. D.  
April 15 1930 (Address) Aberdeen Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Smiths Chapel Cemetery Apr. 16, 1930

20 UNDERTAKER

ADDRESS

Hy. Tarrington &amp; Sons Aberdeen Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH, the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia* *Bronchopneumonia* ("Pneumonia";

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1900  
BUREAU U. S.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County HarfordVillage or City Cardiff (No. \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 184

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary E. Green

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH

Dec 29, 1855  
(Month) (Day) (Year)

7 AGE

74 yrs. 11 mos. 8 ds. or min.?If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country) M. C.10 NAME OF FATHER Rufus H. Pierce

11 BIRTHPLACE OF FATHER

(State or country) Va12 MAIDEN NAME OF MOTHER Eliz. Scott

13 BIRTHPLACE OF MOTHER

(State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw. D. Green(Address) Pyleville Md15 Filed Dec 9-1923H. J. McGabb  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 7, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Oct 27, 1930 to Dec 7, 1930.that I last saw her alive on Dec 6, 1930.and that death occurred on the date stated above, at 4 A m.

The CAUSE OF DEATH \* was as follows:

Carcinoma of Stomach

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary(Signed) James S. Shelbourn M.D.  
Dec 7, 1930 (Address) Cardiff Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagglan Presby. Cemetery Dec 10, 1930

20 UNDERTAKER

ADDRESS

Dean & Fortis Bellin Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer—retired 6 yrs.* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 6 1931

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hagerstown

Village or City near Aberdeen (No. \_\_\_\_\_)

2 FULL NAME Harold J. Griffin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH July 14, 1915  
(Month) (Day) (Year)

7 AGE 15 yrs. 4 mos. 18 ds. or 15 yrs. 4 mos. 18 ds. If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.)

8 OCCUPATION  
(a) Trade, profession or particular kind of work School boy  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) New York City

10 NAME OF FATHER Edward John Griffin

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Bessie Bacht

13 BIRTHPLACE OF MOTHER (State or Country) N. Y.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward J. Griffin

(Address) 618 W 136th St

15 Filed Dec 30 1920 E. J. Griffin  
Registrar

15061 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 1, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from about 7 P.M. to 1930 Dec 1, 1920

that I last saw him alive on \_\_\_\_\_, 1920

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH \* was as follows:

accidently struck by car  
fracture skull

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary hemorrhage

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) W. H. Knite M. D.

Dec 1, 1920 (Address) Aberdeen Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? accident at Aberdeen

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New York City Dec 3, 1920

20 UNDERTAKER ADDRESS

Henry James & Son Aberdeen



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

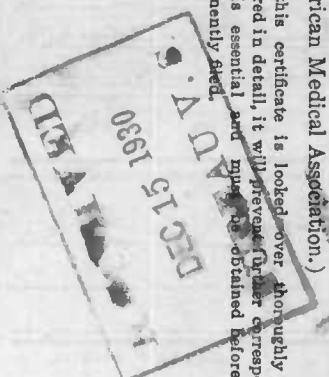
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operations was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





MARGIN RESERVED FOR BINDING  
WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Harford

Village or City

Near Chertoon

2 FULL NAME

Thomas Griffin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

Feb.71868

(Month)

(Day)

(Year)

7 AGE

62 yrs.8 mos.— ds.

If LESS than

1 day \_\_\_\_ hrs.

or \_\_\_\_ min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Day Laborer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Lillian Griffin

(Address)

Chertoon N.D.

15 Filed

Oct 18

1920

O. C. McLeod

Registrar

12495

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

181

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct.16, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Oct 51930 toOct 151930that I last saw him alive on Oct 15, 1930and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH \* was as follows:

Acute Nephritis

(Duration)

yrs.

1 mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

1 mos.

ds.

(Signed)

Chas. H. Hight

M. D.

Oct 181930 (Address)Chertoon

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wm. Calvary CemeteryOct 19, 1930

20 UNDERTAKER

ADDRESS

Henry Tarning Sons Chertoon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, Delirium*) may be stated under the head of "contributory," (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Harford

69326

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

182

Village or City

Fallston (No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Hannah L. Griffiths

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Sept. 14, 1863 (Month) (Day) (Year)

7 AGE

66 yrs. 10 mos. 27 ds. (If LESS than 1 day hrs. or min.)

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

House Wife

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

Aug 7 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 6, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 12, 1930 to Aug 6, 1930, that I last saw her alive on Aug 1, 1930, and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH \* was as follows:

Hemiplegia (Duration) yrs. mos. 25 ds.

Contributory Secondary

Hemiplegia (Duration) yrs. mos. 25 ds. (Signed) W. Millard Stuhler M. D. 8/7 1930 (Address) Fallston Md.

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL DATE OF BURIAL

Friends Cemetery Md. Aug 8, 1930

20 UNDERTAKER

Hornberger &amp; Gross, Benson, Md.

If more blanks are needed, address to Registrar, 13 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			04383		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			(31)		Registration Dist. No. <u>182</u>	
Village or City <u>Fallston</u> (No. <u>0012</u> )			St. <u></u> Ward <u></u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Sophia M. Griffith</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)				
6 DATE OF BIRTH <u>Aug 24, 1912</u> (Month) (Day) (Year)						
7 AGE <u>17 yrs. 8 mos. 30 ds.</u> If LESS than 1 day ____ hrs. or ____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>School Girl.</u> (b) General nature of industry business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Harford Co. Md.</u>						
PARENTS	10 NAME OF FATHER <u>Groom Griffith</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Harford Co. Md.</u>					
	12 MAIDEN NAME OF MOTHER <u>Betha Bull.</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Harford Co. Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Betha Griffith</u> (Address) <u>Fallston Md.</u>						
15 Filed <u>Apr 28 1923</u> <u>M. E. Richardson</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>April 26, 1923</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>April 20, 1923</u> to <u>April 20, 1923</u> , that I last saw her alive on <u>April 20, 1923</u> , and that death occurred on the date stated above, at <u>7 a. m.</u> The CAUSE OF DEATH * was as follows: <u>Tuberculosis</u>						
(Duration) <u>1</u> yrs. ____ mos. ____ ds.						
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.						
(Signed) <u>Charles W. Harrison</u> M. D. <u>Apr 28, 1923</u> (Address) <u>St. Mary B. n. n.</u>						
*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.						
Where was disease contracted, if not at place of death? _____						
Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Rock Spring Cem.</u>						DATE OF BURIAL <u>Apr. 28, 1923</u>
20 UNDERTAKER <u>W. H. H. &amp; Sons</u>						ADDRESS <u>Benson Ind.</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public  
Health Association.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up, on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepsy," "Ehaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Newer wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1930  
BUREAU



WRITE

THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

Village or City

Mar Chapel

(No. —)

St. —

Ward) —

If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

Walter Nelson Griffith

## MEDICAL CERTIFICATE OF DEATH

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Jan 30 1930

(Month)

(Day)

(Year)

7 AGE

mo 9 yrs. 2 mos. 2 ds.

If LESS than

1 day... hrs.

min. ?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

None

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

James T. Griffith

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Carrie Morris

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James T. Griffith

(Address)

Aberdeen, Md.

15

Filed

Oct 2 1923

Registrar

16 DATE OF DEATH

Oct 2

1923

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Apr. 20 1923, to Oct 2 1923

that I last saw him alive on Sep. 30 1923

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH was as follows:

Illness

Contributory  
Secondary

(Duration) ... yrs. ... mos. ... ds.

(Signed)

J. B. O'Brien M.D.

Oct 2 1923 (Address) Harb. &amp; Gm. Co.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... da.

In the State, ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marb. Chapel

Oct 3 1923

20 UNDERTAKER

ADDRESS

H. S. Bailey Harlington, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "roup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SURGICAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. S.



**N. B.--**Every item of information should be carefully supplied. ACE should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County San Francisco

Village or City Obudu (No. \_\_\_\_\_)

2FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St.:.....Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*  
(Write the word)

6 DATE OF BIRTH May 3, 1867  
(Month) (Day) (Year)

7 AGE 63 yrs. 6 mos. 26 ds. If LESS than 1 day.....hrs. or min.?

OCCUPATION  
(a) Trade, profession or particular kind of work Day Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) *Nebraska*

10 NAME OF FATHER *Maxim Gerson*

11 BIRTHPLACE  
OF FATHER  
(State or country) *Germany*

12 MAIDEN NAME  
OF MOTHER *Wm. H. H. H.*

13 BIRTHPLACE  
OF MOTHER  
(State or Country) *Germany*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sub: Trilsney  
(Address) 606 S. Raze St.

15 Filed Nov 3 1923 O. C. Zwick  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
..... 192..... to..... 192.....

that I last saw h ..... alive on ..... 192.....

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:  
*accidentally killed  
 by Railroad -*

(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.

Contributory Fractured skull

Secondary arm and leg

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) \_\_\_\_\_ M. D.  
Nov 29 1938 (Address) Aberdeen MS

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. .... mos. .... ds.      In the State ..... yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death? .....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL <i>Bakers Cemetery</i>	DATE OF BURIAL <i>Dec 18</i> , 19 <i>20</i>
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20 UNDERTAKER	ADDRESS
Henry Tarrington	Chardon

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Very item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Taylor (No. .... St.: .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)12497 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 1832 FULL NAME William B. Gross

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <b>Male</b>	4 COLOR OR RACE <b>White</b>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <b>Widowed</b> (Write the word)
----------------------	---------------------------------	--

## 6 DATE OF BIRTH

Jan. 5, 1846  
(Month) (Day) (Year)

## 7 AGE

84 yrs. .... 9 mos. .... 15 ds. or .... min. ?  
If LESS than 1 day.... hrs.

## OCCUPATION

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed or (employer) .....

## 9 BIRTHPLACE

(State or country)

Harford Co Md.

## 10 NAME OF FATHER

Jacob L. Gross

## 11 BIRTHPLACE OF FATHER

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Keziah Briley

## 13 BIRTHPLACE OF MOTHER

(State or country)

Harford Co. Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wilmer Gross(Address) Monkton Md

15

Filed Oct 21 1930 Thomas P. Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Oct 20, 1930  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended the deceased from

Oct 20, 1930, to Oct 20, 1930that I last saw him alive on Oct 20, 1930and that death occurred on the date stated above, at 1 P.M.

## The CAUSE OF DEATH was, as follows:

Fracture of skull causing intracranial hemorrhage caused by fall by being struck by a truck  
(Duration) .... yrs. .... mos. 5 hoursContributory  
Secondary

(Duration) .... yrs. .... mos. .... da.

(Signed) H. F. Bradley M. D.Oct 21, 1930 (Address) Jarrettsville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .... yrs. .... mos. .... da. In the State, .... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Bethel Cem.Oct 22, 1930

## 20 UNDERTAKER

## ADDRESS

E. G. Kurtz & SonJarrettsville Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scalic," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 9 1907

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified--Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Harford Co.

10472

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180Village or City Joppa (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup>FULL NAME Catherine West Gummel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED unmarried  
(Write the word)

6 DATE OF BIRTH

May 9, 1861  
(Month) (Day) (Year)

7 AGE

69 yrs. 3 mos. 24 ds. or min.?IF LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)Balt. City Md.

10 NAME OF FATHER

Geo. W. Goshell11 BIRTHPLACE OF FATHER  
(State or country)Balt. Md.

12 MAIDEN NAME OF MOTHER

Catherine Francis Ford.13 BIRTHPLACE OF MOTHER  
(State or country)Born at sea under British flag.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence D. West Gummel(Address) 220 St. Helena Ave15 Filed Sept 7, 1930 Fred Charlack  
local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 2, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept 1, 1930 to Sept 2, 1930that I last saw him alive on Sept 1, 1930and that death occurred on the date stated above, at 8:20 A.M.

The CAUSE OF DEATH \* was as follows:

Acute Endocarditis.(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Charles Benson M. D.Sept 3, 1930 (Address) Kingsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Trinity Lutheran Church Sept 5, 1930

20 UNDERTAKER

ADDRESS

Howard K McComas Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For-man," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former occupation 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Libillheria* avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 4 1930

PUBLIC HEALTH



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Morrisville (No. 31)

2 FULL NAME Anna Hazel Gummill

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 183

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female white 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Apr 8, 1 1897 (Month) (Day) (Year)

7 AGE 33 yrs. 7 mos. 1 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION (a) Trade, profession or particular kind of work Housewife (b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Harford Co Md

10 NAME OF FATHER Charles Seib

11 BIRTHPLACE OF FATHER (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Anna Sophia Orwig

13 BIRTHPLACE OF MOTHER (State or Country) York Co Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant) Meyrtle Gibbs Susie

(Address) Stewartstown Pa

15 Filed Nov. 9 1930 Thomas R. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 7, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 3, 1930 to Nov 7, 1930, that I last saw him alive on Nov 7, 1930,

and that death occurred on the date stated above, at 59 M. The CAUSE OF DEATH \* was as follows:

Laryngeal Tuberculosis (Duration) 1 yrs. 6 mos. \_\_\_\_\_ ds.

Contributory Secondary (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Ernest M. Pies M. D. Nov 7 1930 (Address) Stewartstown Pa

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence Harford Co Md

19 PLACE OF BURIAL OR REMOVAL Morrisville Md DATE OF BURIAL Nov 10, 1930

20 UNDERTAKER H. H. Webb ADDRESS East Gore Pa



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiovascular fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysentheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart-failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Hartford

STATE OF MARYLAND  
6504 CERTIFICATE OF DEATH

Registration Dist. No. 184

Village or City

Dublin

(No. ....)

St. ....

Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

David Henry Haines

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Cae

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Aug 16, 1907  
(Month) (Day) (Year)

7 AGE

22 yrs. 5 mos. 0 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

David Haines

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Molly Harris

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Molly Haines

(Address)

1 Street Md

15

Filed

Jan 16, 1930 M. O. Kirk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 12, 1930 to Jan 16, 1930, that I last saw him alive on Jan 12, 1930, and that death occurred on the date stated above, at 4 P. M.

THE CAUSE OF DEATH \* was as follows:

Tuberculosis (Duration about 2 yrs. 4 mos. 4 ds.)

Contributory  
Secondary(Signed) T. E. Gallion, M. D.  
Jan 17, 1930 (Address) Eastington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hosanna Md

1/20, 1930

20 UNDERTAKER

ADDRESS

H. S. Bailey

Dorchester



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary foreman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (c) Soteman. (b) (c) (d) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Teacher," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Scar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*. . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

1 PLACE OF DEATH

County

Arford

Village or City

Dublin

(No. -

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St. - Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Elizabeth M. Haines

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Aug. 22, 1915

(Month)

(Day)

(Year)

7 AGE

14 yrs. 7 mos. 26 ds. or min.?

If LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Schoolgirl

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Fulton Hainer

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Lorena Day

13 BIRTHPLACE OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Fulton Hainer

(Address)

10 Arlington Md.

15

Filed

April 17, 1930 M. H. Haines

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 17, 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

April 11, 1930 to April 17, 1930

that I last saw her alive on April 17, 1930

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH \* was as follows:

Scarlet fever

(Duration) yrs. mos. 7 ds.

Contributory Secondary

Natural

(Duration) yrs. mos. ds.

(Signed)

L. P. Sinsgrava M. D.

4-17-1930 (Address) 10 Arlington Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dublin, Md. April 18, 1930

20 UNDERTAKER

ADDRESS

H. S. Bailey 10 Arlington Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Harford

0505

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

Village or City Chesapeake (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Ruthia Hall

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH November 16, 1869  
(Month) (Day) (Year)

7 AGE 60 yrs. 1 mos. 20 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Joseph Hall

(Address) Chesapeake Md

15 Filed Jan 11 1923 O. C. McNeil  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 9, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 2 1923 to Jan 9 1923  
that I last saw him alive on \_\_\_\_\_, 1923

and that death occurred on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH was as follows:  
Chronic Hypertrophic  
Atherosclerosis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Dr. J. S. Jones M. D.  
Jan 11 1923 (Address) Chesapeake Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union M. E. Cemetery Jan 12, 1923

20 UNDERTAKER

ADDRESS

Henry Tanning Chesapeake Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 6 1930  
BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Harford*

Village or City

*Pylesville*

(No. \_\_\_\_\_)

2 FULL NAME

*James H. Hall*STATE OF MARYLAND  
CERTIFICATE OF DEATH

13848

(14a)

Registration Dist. No.

*184*

St.: \_\_\_\_\_ Ward) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*Colored*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*married*

6 DATE OF BIRTH

*1852*

(Month) \_\_\_\_\_

(Day) \_\_\_\_\_

(Year) \_\_\_\_\_

7 AGE

*78* yrs.

mos. \_\_\_\_\_

ds. \_\_\_\_\_

If LESS than

1 day \_\_\_\_\_ hrs.

or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Labourer*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*md*

10 NAME OF FATHER

*James Hall*

11 BIRTHPLACE OF FATHER

(State or country)

*md.*

12 MAIDEN NAME OF MOTHER

*Caroline Mayan*

13 BIRTHPLACE OF MOTHER

(State or Country)

*md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Charles Hall*

(Address)

*Whitely md.*

15 Filed

*Dec 2 1923*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Nov 30**1920*

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

17

I HEREBY CERTIFY, That I attended the deceased from

*Nov 30**1920*to *Nov 30**1920*that I last saw him alive on *Nov 30**1920*and that death occurred on the date stated above, at *11:40 P.M.*

The CAUSE OF DEATH \* was as follows:

*Haemorrhage of Brain*

(Duration) \_\_\_\_\_

yrs. \_\_\_\_\_

mos. \_\_\_\_\_

ds. \_\_\_\_\_

Contributory  
Secondary

(Duration) \_\_\_\_\_

yrs. \_\_\_\_\_

mos. \_\_\_\_\_

ds. \_\_\_\_\_

(Signed)

*Charles W. Mayan* M. D.*Dec 1**1920*

(Address)

*Grey St. md.*

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

In the

State

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Christ Church Cemetery**Dec 2, 1920*

20 UNDERTAKER

ADDRESS

*John L. Norris**Bella Pa*

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 4 1930



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## 1 PLACE OF DEATH

County

Hampden

04385

74a

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

183

Village or City

Rocky

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mary Hall

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Dec 13, 1865  
(Month) (Day) (Year)

7 AGE

66 yrs. 4 mos. 13 ds. or min.  
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Samuel Simons

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Debra Chase

13 BIRTHPLACE OF MOTHER

(State or Country)

Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Rice

(Address)

1000 W. 10th St. Baltimore, Md

15 Filed

Oct 26, 1930 Thomas R. Bryson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 25, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

April 11, 1930 to Apr. 25, 1930  
that I last saw him alive on Apr. 25, 1930and that death occurred on the date stated above, at 12:30 p.m.  
The CAUSE OF DEATH \* was as follows:

apoplexy

Contributory  
Secondary(Duration) yrs. mos. ds.  
(Signed) M. E. Arthur M. D.  
Apr. 25, 1930 (Address) Cardiff, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chestnut Grove Md April 27, 1930

20 UNDERTAKER

ADDRESS

H. K. Webb



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the heading "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 5 1930  
BUREAU



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1 PLACE OF DEATH

County

*Harford*

WITHIN CORPORATE LIMITS OF

10473

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *185*Village or City *Hdels Grace*, (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Andrew Hamler*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male white*

4 COLOR OR RACE

5 SINGLE

MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*widower*

6 DATE OF BIRTH

*August 12, 1837*  
(Month) (Day) (Year)

7 AGE

*93* yrs. *4* mos. *28* ds. or min.?If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*labor*

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)*New Jersey*10 NAME OF  
FATHER*Andrew Hamler, Sr.*

PARENTS

11 BIRTHPLACE  
OF FATHER*New Jersey*12 MAIDEN NAME  
OF MOTHER*Mary Allen*13 BIRTHPLACE  
OF MOTHER*New Jersey*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs. J. Robinson*

(Address)

*Hdels Grace, Md.*

15

Filed

*Sept. 11, 1930* *Chas. J. Foley, M.D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Sept 10, 1930*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
*June 1, 1930* to *Sept 10, 1930*  
that I last saw him alive on *Sept 10, 1930*and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:*Pulmonary edema*Contributory  
Secondary*Arterio Sclerosis*  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

*J. L. Hopkins* M. D.  
*Sept. 11, 1930* (Address) *Hdels Grace*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Tranquillity Cemetery, Sept. 13, 1930*

20 UNDERTAKER

ADDRESS

*Wm. H. H. H. Hdels Grace, Md.*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

BUREAU



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Hartford  
County Casovary

Village or City Casovary (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2 FULL NAME Frederick Hanson

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Aug 11 1858  
(Month) (Day) (Year)

7 AGE 72 yrs. 2 mos. 15 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Mo

10 NAME OF FATHER Ford B Hanson

11 BIRTHPLACE OF FATHER (State or country) Mo

12 MAIDEN NAME OF MOTHER Annaliza Greenland

13 BIRTHPLACE OF MOTHER (State or Country) Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eliza Ellen P. Hanson  
(Address) Aberdeen Md

15 Filed Oct 28 1930 Virginia Chambers  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 26 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 1 1929 to Oct 25 1930

that I last saw him alive on Oct 25 1930

and that death occurred on the date stated above, at 12 31 A.m.

The CAUSE OF DEATH \* was as follows:

Paralysis (Left Hemiplegia)  
(Duration) 3 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Arterio Sclerosis

(Signed) J. L. Hopson M. D.  
Oct 26 1930 (Address) Hartford

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Presbyterian Church DATE OF BURIAL Oct 28 1930

20 UNDERTAKER Dean & Foster ADDRESS Bell Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. 2.



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PLACE OF DEATH

County

Village or City

(No. 105)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

July 2, 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Nov 1, 1929, to Dec 30, 1929,

that I last saw him alive on Dec 30, 1929,

and that death occurred on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH \* was as follows:

Carcinoma Liver, Gall Bladder  
Metastasis mesenteric & Lung  
(Right) (Duration) 1 yrs. mos. ds.  
Contributory Cachexia  
Secondary (Duration) 2 yrs. mos. ds.

(Signed) Charles J. Foley M.D.

July 1, 1930 (Address) Aberdeen, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Center Cemetery July 2, 1930

20 UNDERTAKER

ADDRESS

Hy. Tarring &amp; Sons Aberdeen, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds., Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
AUG 5 1930



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Hanford*

Village or City

*Whiteford*

(No. \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *184*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Franklin B. Harman*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 SINGLE

*Married*  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

*May 27, 1861*  
(Month) (Day) (Year)

7 AGE

*68* yrs. *8* mos. *8* ds. or min.?If LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

*Quarryman*

9 BIRTHPLACE

(State or country)

*Pa.*

10 NAME OF FATHER

*Samuel Harman*

11 BIRTHPLACE OF FATHER

(State or country)

*Not Known*

12 MAIDEN NAME OF MOTHER

*Bernie Ruth Kuntz*

13 BIRTHPLACE OF MOTHER

(State or country)

*Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Rachel Harman*

(Address)

*Whiteford*

15

Filed *Feb. 7, 1930**H. J. McNabb*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Feb 5, 1930*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *Jan 1, 1930* to *Feb 5, 1930*.that I last saw him alive on *Feb 5, 1930*.and that death occurred on the date stated above, at *7 P.M.*

The CAUSE OF DEATH \* was as follows:

*Bronchitis, followed by Lobar Pneumonia*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

*H. E. Arthur* M. D.  
*Feb 5, 1930* (Address) *Quincy Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*State Ridge Cemetery**Feb. 8, 1930*

20 UNDERTAKER

ADDRESS

*W. J. Halden**Delta Pa*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *the pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Chapin

03027

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180Village or City Joppa (No. \_\_\_\_\_)

St.: \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mark Pauline Ramsey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Jan 5, 1875  
(Month) (Day) (Year)

7 AGE 55 yrs. 1 mos. 26 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Richard Stolze

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Annebei Kriss

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Ramsey(Address) Joppa Md

15 Filed March 5 1920 Fred Houlton  
local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 4, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 25 1929 to Mar 4 19230

that I last saw him alive on Mar 4, 19230

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Chas Roth M. D.  
Mar 4 19230 (Address) Edgewood Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Trinity Luthern Cemetery Mar. 7, 1930

20 UNDERTAKER ADDRESS  
Howard K. McComas, Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 3 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS OF

08082

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Harre de Grace

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

Harriet J. Harris

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Widow

6 DATE OF BIRTH

Jan

13

1862

(Month)

(Day)

(Year)

7 AGE

68 yrs.

6 mos.

9 ds.

If LESS than

1 day

hrs.

or min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Richard Brown

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Fannie Buchanan

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Herbert Brown

(Address)

Harre de Grace Md

15 Filed

July 24 1930

Charles J. Toly, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 22

1930

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended the deceased from Jan 1 1930 to July 22 1930

that I last saw her alive on July 21 1930

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH \* was as follows:

Chronic Nephritis  
DropsyContributory  
SecondaryArterio sclerosis  
(Duration) yrs. 6 mos. ds.

(Signed)

J. H. Hopson M. D.  
July 25 1930 (Address) Harre de Grace Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union M. E. Cemetery

July 25 1930

20 UNDERTAKER

ADDRESS

Henry Tarrington

Chesden



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (mere symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Harford*

12894

(756)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *182*Village or City *County Home* (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

*John Harris*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>male</i>	4 COLOR OR RACE <i>col</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Unknown</i>
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6 DATE OF BIRTH <i>Unknown</i>	1 (Month) (Day) (Year)
-----------------------------------	---------------------------

7 AGE <i>about 80</i>	80 yrs. mos. ds. or min.?	If LESS than 1 day hrs.
--------------------------	---------------------------	-------------------------

8 OCCUPATION (a) Trade, profession or particular kind of work <i>None</i> (b) General nature of industry business, or establishment in which employed (or employer)
--

9 BIRTHPLACE (State or country) <i>Unknown</i>
---

10 NAME OF FATHER <i>Unknown</i>
11 BIRTHPLACE OF FATHER (State or country) <i>Unknown</i>
12 MAIDEN NAME OF MOTHER <i>Unknown</i>
13 BIRTHPLACE OF MOTHER (State or country) <i>Unknown</i>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Clark Fitzpatrick*

(Address)

*Bel Air Md*

15 Filed <i>Oct 11 1930</i>	<i>W. E. Richardson</i> Registrar
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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <i>Oct 10 1930</i>	(Month) (Day) (Year)
--	----------------------

17 I HEREBY CERTIFY, That I attended the deceased from <i>1929</i> to <i>Oct 10</i> , 192 <i>9</i>
--

that I last saw him alive on *Oct. 3*, 19*30*and that death occurred on the date stated above, at *2:15 P.* m.

The CAUSE OF DEATH \* was as follows:

*Paralysis (Chronic)**St*(Duration) *2* yrs. mos. ds.Contributory  
Secondary

(Signed) <i>Chas. Richardson</i>	(Duration) yrs. mos. ds.	M. D.
<i>Oct 11 1930</i>	(Address) <i>Bel Air Md.</i>	

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death *1* yrs. mos. ds. In the State *1* yrs. mos. ds.Where was disease contracted, if not at place of death? *Unknown*Former or usual residence *Bel Air*

19 PLACE OF BURIAL OR REMOVAL <i>County Home</i>	DATE OF BURIAL <i>Oct 10 1930</i>
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20 UNDERTAKER <i>Dean Harris</i>	ADDRESS <i>Bel Air Md</i>
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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

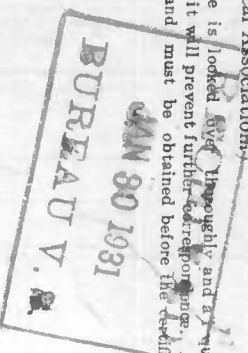
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Belleville (No. \_\_\_\_\_)2 FULL NAME Lydia Ann HarrySTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 184
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

 6 DATE OF BIRTH Jan 18, 1858  
 (Month) (Day) (Year)

 7 AGE 80 yrs. 1 mos. 0 ds. or min.?  
 If LESS than 1 day \_\_\_\_ hrs.

 8 OCCUPATION  
 (a) Trade, profession or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

 9 BIRTHPLACE (State or country) Pa

 10 NAME OF FATHER John Harmon

 11 BIRTHPLACE OF FATHER (State or country) Pa

 12 MAIDEN NAME OF MOTHER Susan Young

 13 BIRTHPLACE OF MOTHER (State or Country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) John Harry  
 (Address) Belleville Md

 15 Filed Feb 12 1938 of J. McCrell  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH Feb 18, 1938  
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from Jan. 1 1938 to Feb 15 1938  
 that I last saw her alive on Feb 15 1938

 and that death occurred on the date stated above, at 6:30 P. M.  
 The CAUSE OF DEATH \* was as follows:
Organic Heart disease
 Contributory  
 Secondary

 (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
 (Signed) Charles W. Harmon M. D.  
Feb 19 1938 (Address) 804 B. and

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

 19 PLACE OF BURIAL OR REMOVAL Bellowsbury DATE OF BURIAL Feb 22, 1938

 20 UNDERTAKER J. H. Webb ADDRESS 1000 N. Howard



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Emaciation," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—occident; Renal wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 8 1920  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Harford

St.: Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Barbara M. Hasenei

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

March 12, 1923

7 AGE

7 yrs. 9 mos. 9 ds.

If LESS than 1 day hrs. or min.)

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

George P. Hasenei

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Marie Bernw.

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. P. Hasenei

(Address)

Baltimore, Md.

15

Filed Dec. 22, 1920 Charles J. Foley, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 22nd, 1920

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1920 to 1920

that I last saw him alive on 1920

and that death occurred on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage from Fractured Skull

(Duration) yrs. mos. ds.

Contributory Secondary

Automobile Accident

(Duration) yrs. mos. ds.

(Signed) Martin P. Foley, Coroner M. D.

Dec. 22, 1920 (Address) Harford, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery, Dec. 24, 1920

20 UNDERTAKER

ADDRESS

Bennington &amp; Son, Baltimore, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Soleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 3 1931  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

01730

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

182

Village or City

Kalmia

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John Haughay

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Feb. 19, 1847

(Month)

(Day)

(Year)

7 AGE

83

yrs.

mos.

8

ds.

If LESS than

1 day \_\_\_\_\_ hrs.

or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Bernard Haughay

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Sarah Flomer

13 BIRTHPLACE OF MOTHER

(State or Country)

Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Ruby Haughay

(Address)

Bel Air, Md.

15 Filed

Feb 27 1930

E. Richardson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 27

1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Feb 26

1930

to Feb 27

1930

that I last saw him alive on Feb 27, 1930

and that death occurred on the date stated above, at 12:50 P. M.

The CAUSE OF DEATH \* was as follows:

Uremia, Remitting Chronic Interstitial Nephritis

Contributory Secondary

Prostatic Hypertrophy

(Signed)

Willard P. Hudson

M. D.

Feb 27 1930

(Address)

Forest Hill, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas Run Am

March 1, 1930

20 UNDERTAKER

ADDRESS

A. J. Bailey Harlington



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 5 1930

BUREAU



N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

14234

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village

Kalmia (No. -)

St.:

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Lizzie Haughay

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE

MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widow

6 DATE OF BIRTH

March 20, 1855

(Month)

(Day)

(Year)

7 AGE

75 yrs. 8 mos. 6 ds. If LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

Housework

9 BIRTHPLACE

(State or country)

Pa.

10 NAME OF FATHER

Wm. Booth

11 BIRTHPLACE OF FATHER

(State or country)

England

12 MAIDEN NAME OF MOTHER

Elizabeth Byram

13 BIRTHPLACE OF MOTHER

(State or country)

England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ruthie Haughay

(Address)

Bel-air, Md.

15

Filed Nov. 29, 1930 V. C. Chambers

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 26, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct. 21, 1930 to Nov. 26, 1930

that I last saw her alive on Nov. 26, 1930

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH \* was as follows:

Chronic endocarditis

(Duration) 15 yrs. mos. ds.

Contributory Secondary

Solar pneumonia

(Duration) yrs. mos. 3 ds.

(Signed)

W. E. Sallion

M. D.

Nov. 27, 1930

(Address) Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas Run Cem, Nov. 29, 1930

20 UNDERTAKER

ADDRESS

H. S. Bailey Harlington, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

JAN 9 1931  
BUREAU



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1 PLACE OF DEATH		WITHIN CORPORATE LIMITS OF		01731 STATE OF MARYLAND	
County <u>Harford</u>		(117)		CERTIFICATE OF DEATH	
Village or City <u>Hdelsrace</u> (No. _____)		Hospital <u>Hospital</u> St.: _____		Ward) _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Estella M. Hawkins</u>		Registration Dist. No. <u>185</u>			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female colored</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Feb. 28 - 1917</u> (Month) (Day) (Year)					
7 AGE <u>12 yrs. 11 mos. 12 ds.</u> If LESS than 1 day ____ hrs. or ____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>George Hawkins</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Mattie Webster</u>				
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Geo. Hawkins</u> (Address) <u>Chapin, Md.</u>					
15 Filed <u>Feb. 13, 1930</u> <u>Chas. J. Fay, M.D.</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Apr 11, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 29, 1930</u> to <u>Apr 11, 1930</u> , that I last saw him alive on <u>Apr 10, 1930</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Acute Singsnow Appendicitis</u> (Duration) ____ yrs. ____ mos. ____ ds. Contributory Secondary <u>Peritonitis + Substernal obstruction</u> (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>J. M. Spence</u> M. D. <u>Apr 12, 1930</u> Address <u>Harford, Md.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Gravelly Hill</u>				DATE OF BURIAL <u>Feb. 13, 1930</u>	
20 UNDERTAKER <u>Bennington, Son</u>				ADDRESS <u>Hdelsrace, Md.</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Harford

WITHIN CORPORATE LIMITS OF

12499

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Harford (No. Harford St. Harford Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Eugene Thomas Hawks

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Ches.

6 DATE OF BIRTH January 24, 1928  
(Month) (Day) (Year)

7 AGE 2 yrs. 9 mos. - ds. If LESS than 1 day - hrs. or - min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Ches.  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Darlington, Mo.

10 NAME OF FATHER Leay Hawks

11 BIRTHPLACE OF FATHER (State or country) Raywood, Va.

12 MAIDEN NAME OF MOTHER May Thomas

13 BIRTHPLACE OF MOTHER (State or Country) Gladespring, Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) May Thomas Hawks  
(Address) Darlington, Mo.

15 Filed Oct. 18, 1930 by Charles J. Foley M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 1930

that I last saw him alive on 1930, and that death occurred on the date stated above, at 7:35 P.m.

The CAUSE OF DEATH \* was as follows:  
Internal Hemorrhage. Caused by  
being accidentally struck by Automobile  
Truck on State Road near Darlington Md

(Duration) - yrs. - mos. - ds.  
Contributory Child running across road  
Secondary

(Signed) Martin P. Foley "Coroner" M. D.  
October 17, 1930 (Address) Harford, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 5 hours at Harford In the State 2 yrs. 9 mos. - ds.

Where was disease contracted, if not at place of death? Hit by Automobile Truck near

Former or usual residence Near Darlington, Harford County Md.

19 PLACE OF BURIAL OR REMOVAL Dublin Cemetery DATE OF BURIAL Oct. 19, 1930

20 UNDERTAKER H. S. Bailey ADDRESS Darlington, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs).* For persons who have no occupation, whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Jarrettsville (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Baby Havens15063 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 183

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Dec. 9, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 15 min. ?  
If LESS than 1 day....hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) \*\*\*

9 BIRTHPLACE (State or country) Harford Co. Md.

PARENTS  
10 NAME OF FATHER Willis Havens  
11 BIRTHPLACE OF FATHER (State or country) Va.  
12 MAIDEN NAME OF MOTHER Carrie M. Gore  
13 BIRTHPLACE OF MOTHER (State or country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Willis Havens(Address) Jarrettsville, Md.

15 Filed Dec. 10, 1930 Thomas R. Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 9, 1930, to Dec 9, 1930.

that I last saw her alive on Dec 9, 1930.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH was as follows:

Unknown - Probably Asphyxiation -  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 0 ds.

Contributory  
Secondary

(Signed) Wilford J. Hudson M. D.  
Dec 9, 1930 (Address) Forest Hill Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cooptown Cemetery Dec. 10, 1930

20 UNDERTAKER ADDRESS

E. G. Kurtz & Son Jarrettsville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Colic," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.) If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<p>1 PLACE OF DEATH County <u>Harford</u></p>		<p>15065</p>		<p>STATE OF MARYLAND CERTIFICATE OF DEATH</p>	
<p>Village or City <u>Beech</u> (No. <u>44</u>)</p>		<p>St. _____ Ward _____</p>		<p>Registration Dist. No. <u>182</u></p>	
<p>2 FULL NAME <u>May Louisa Hewitt</u></p>					
<p>PERSONAL AND STATISTICAL PARTICULARS</p>					
<p>3 SEX <u>Female</u></p>	<p>4 COLOR OR RACE <u>Colored</u></p>	<p>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u></p>	<p>16 DATE OF DEATH <u>Dec 7</u>, 19<u>30</u> (Month) (Day) (Year)</p>		
<p>6 DATE OF BIRTH <u>Oct 14</u>, 19<u>63</u> (Month) (Day) (Year)</p>			<p>17 I HEREBY CERTIFY, That I attended the deceased from 192<u>2</u> to <u>Dec</u>, 19<u>30</u>, that I last saw h<u>er</u> alive on <u>Dec 3</u>, 19<u>30</u>, and that death occurred on the date stated above, at <u>9-10 a.m.</u></p>		
<p>7 AGE <u>67</u> yrs. <u>2</u> mos. <u>23</u> ds. or _____ min.?</p>			<p>IF LESS than 1 day _____ hrs. The CAUSE OF DEATH * was as follows: <u>Carcinoma Stomach</u></p>		
<p>8 OCCUPATION (a) Trade, profession or particular kind of work <u>House Maid</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____</p>			<p>(Duration) <u>1</u> yrs. <u>2</u> mos. _____ ds.</p>		
<p>9 BIRTHPLACE (State or country) <u>Md</u></p>			<p>Contributory Secondary _____</p>		
<p>10 NAME OF FATHER <u>Wesley Moore</u></p>			<p>(Signed) <u>W. H. H. H.</u> M. D. <u>Dec 8</u>, 19<u>30</u> (Address) <u>Bell Air Md</u></p>		
<p>11 BIRTHPLACE OF FATHER (State or country) <u>Md</u></p>			<p>*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.</p>		
<p>12 MAIDEN NAME OF MOTHER <u>Ann Thompson</u></p>			<p>18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.</p>		
<p>13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u></p>			<p>Where was disease contracted, if not at place of death? _____ Former or usual residence _____</p>		
<p>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wesley Hewitt</u> (Address) <u>Bell Air Md</u></p>					
<p>15 Filed <u>Dec 9</u>, 19<u>30</u> <u>D. E. Chambers</u> Registrar</p>			<p>19 PLACE OF BURIAL OR REMOVAL <u>Salisbury</u></p>		
			<p>20 UNDERTAKER <u>Dean Foster</u></p>		
			<p>DATE OF BURIAL <u>Dec. 9</u>, 19<u>30</u></p>		
			<p>ADDRESS <u>Bell Air</u></p>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia,"

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.); "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

1930  
67  
1963



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1 PLACE OF DEATH

County Hanford

WITHIN CORPORATE LIMITS OF

10474

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Hanford General Hospital (No.       )St.        Ward       

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME G. Duane Hayes

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIEDWIDOWEDOR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

June 11<sup>th</sup> 1901  
(Month) (Day) (Year)

7 AGE

29 yrs. 2 mos.        ds. or        min.?IF LESS than  
1 day        hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Power House

(b) General nature of industry, business, or establishment in which employed or (employer)

Fireman

9 BIRTHPLACE

(State or country)

Latta, South Carolina

10 NAME OF FATHER

J. R. Hayes

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

Latta, South Carolina

12 MAIDEN NAME OF MOTHER

Ella F. Hayes

13 BIRTHPLACE OF MOTHER

(State or Country)

Latta, South Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert R. Hayes(Address) 275 Evergreen Ave.

15 Filed

Sept. 6, 1930 Chas. J. Foley, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September (Month) 5 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from September 3<sup>rd</sup> 1930 to Sept. 5<sup>th</sup> 1930.that I last saw him alive on September 5<sup>th</sup> 1930.and that death occurred on the date stated above, at 4:30 P. m.  
The CAUSE OF DEATH \* was as follows:Lober Pneumonia  
Chronic Nephritis  
(Duration)        yrs.        mos.        ds.Contributory  
Secondary(Signed) [Signature] M. D.  
1930 (Address) [Address]

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death        yrs.        mos.        ds.In the State        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

South Carolina

DATE OF BURIAL

Sept 7 1930

20 UNDERTAKER

Howard K McNamee

ADDRESS

Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by acetic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u>		13849 (740)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Aberdeen</u> (No. <u>Paradise Road</u> Ward)		Registration Dist. No. <u>141</u>			
2 FULL NAME <u>Sarah Frances Hendon</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>June 30 1834</u> (Month) (Day) (Year)					
7 AGE <u>96</u> yrs. <u>4</u> mos. <u>27</u> ds. or min.?					
OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>School teacher &amp; Nurse</u>					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Thomas Hendon</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Mary Amanda</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Harry Davis Coal Co.</u> <u>R. F. D. #11 Aberdeen, Md.</u> (Address)					
15 Filed <u>11/27</u> 192 <u>30</u> <u>O. K. Mitchell</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov. 27</u> , 192 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>11-27-30</u> 192 <u>30</u> to <u>11-27-30</u> 192 <u>30</u> , that I last saw her alive on <u>Nov 27</u> , 192 <u>30</u> , and that death occurred on the date stated above, at <u>9:30 P. M.</u>					
The CAUSE OF DEATH * was as follows: <u>Cerebral Hemorrhage</u> <u>producing paralysis</u>					
(Duration) yrs. mos. ds.					
Contributory Secondary <u>Diabetes mellitus</u> <u>Cholera</u> (Duration) yrs. mos. ds.					
(Signed) <u>J. N. Otter</u> M. D. <u>11-27</u> 192 <u>30</u> (Address) <u>Priggen, Md.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)					
At place of death yrs. mos. ds. In the State yrs. mos. ds.					
Where was disease contracted, if not at place of death?					
Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Sally Family Cem.</u>					DATE OF BURIAL <u>Dec 1, 1930</u>
20 UNDERTAKER <u>R. Madison Mitchell</u>					ADDRESS <u>Harford</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 6 1930

BUREAU



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

09327

8

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than 1 day 0 hrs. 0 min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory Secondary

(Signed)

\* State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 SIGNATURE

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

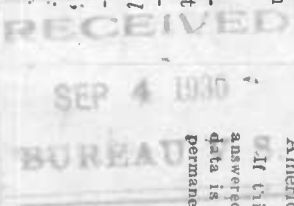
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never reject "Typhoid Pneumonia"; *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia";

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dr. opsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.





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1 PLACE OF DEATH  
County Harford

Village or City Stonemansville (No. 12)

2 FULL NAME Charles Ezekiel Herbert

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 183

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Jan - 31<sup>st</sup>, 1867  
(Month) (Day) (Year)

7 AGE 63 yrs. 6 mos. 23 ds. IF LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Labourer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Penn

10 NAME OF FATHER Richard E. Herbert

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER Lottie Malin

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Clara Herbert

(Address) Tacon Grove Pk

15 Filed Aug 26 1930 Thomas R Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August - 23<sup>rd</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug - 13<sup>th</sup> 1930 to Aug - 23<sup>rd</sup> 1930, that I last saw him alive on Aug 23<sup>rd</sup> 1930

and that death occurred on the date stated above, at 5 A.M.  
The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

(Duration) 10 yrs. 10 mos. 10 ds.  
Contributory Secondary same

(Signed) Vallie Sawyers M. D.  
Aug 24 1930 (Address) Tacon Grove Pk

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 10 yrs. 10 mos. 10 ds. In the State 10 yrs. 10 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Pauls Cemetery DATE OF BURIAL Aug 24, 1930

20 UNDERTAKER J. H. Holt ADDRESS Tacon Grove Pk



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BURIAL  
WRITE HERE, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		04386		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>		(15-a)		Registration Dist. No. <u>185</u>	
Village or City <u>Hdels Grace</u> (No. _____)		St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Jacob J. Hergenrother</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>Apr 19 1930</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>May 5 1848</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Mar 1 1928</u> to <u>Apr 19 1930</u> that I last saw him alive on <u>Apr 19 1930</u> and that death occurred on the date stated above, at <u>4 P. M.</u> The CAUSE OF DEATH * was as follows: <u>Paralysis (Right Hemiplegia)</u>		
7 AGE <u>81</u> yrs. <u>11</u> mos. <u>14</u> ds. or min.?			If LESS than 1 day ____ hrs.		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Shoe Maker.</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			Contributory Secondary <u>Arteriosclerosis</u> (Duration) ____ yrs. ____ mos. ____ ds.		
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>			(Signed) <u>J. Lee J. J. J.</u> M. D. <u>Apr 20 1930</u> (Address) <u>Harford</u>		
PARENTS	10 NAME OF FATHER <u>John M. Hergenrother</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
	11 BIRTHPLACE OF FATHER <u>France</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.		
	12 MAIDEN NAME OF MOTHER <u>May Brann</u>		Where was disease contracted, if not at place of death? Former or usual residence _____		
	13 BIRTHPLACE OF MOTHER <u>France</u>		19 PLACE OF BURIAL OR REMOVAL <u>MT. Zion</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Hergenrother</u> (Address) <u>Hdels Grace, Md.</u>					
15 Filed <u>April 22, 1930</u> <u>Chas. J. Foley, M.D.</u> Registrar			20 UNDERTAKER <u>Pennington &amp; Co. Hdels Grace, Md.</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 5 1930  
BUREAU 7.8



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1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Dec 19 1930

Thomas R. Brown

Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

15066

Registration Dist. No. 183

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY That I attended the deceased from

Sept 13 1928 to Dec 18 1930

that I last saw him alive on Dec 17 1930

and that death occurred on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis

Contributory Secondary

(Duration) 10 yrs. 3 mos. 3 days

(Duration) 3 yrs. 3 mos. 3 days

(Signed) James A. Free M. D.

Dec 19 1930 (Address) Stencartstown

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

10 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. da.

In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Copus Chapel

Dec 20 1930

20 UNDERTAKER

ADDRESS

Philips Washington

White Hall Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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JAN 2 1931

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by tartaric acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS OF

(90)

STATE OF MARYLAND  
6506 CERTIFICATE OF DEATH

Registration Dist. No.

185

Village or City

Hdelsrace, Md.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Lurina Holland

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female colored

4 COLOR OR RACE

5 SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Widow

6 DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7 AGE

abt 50

yrs.

mos.

ds.

or min.)

IF LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Charles Dors.

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Susan Scott.

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mella Norfield

(Address)

Hdelsrace, Md.

15

Filed

Jan. 4, 1930

Chas. J. Foley, Jr.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 1st, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec. 8th, 1930 to Jan 1st, 1930

that I last saw him alive on Dec. 30th, 1930,

and that death occurred on the date stated above, at 10 p.m.

The CAUSE OF DEATH \* was as follows:

acute Cardiac dilatation

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

Cordine Asthma

(Duration)

yrs.

mos.

ds.

(Signed)

James H. Bay

M. D.

Jan 3rd, 1930

(Address)

Horn Island

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asbury Cemetery

Jan. 5, 1930

20 UNDERTAKER

ADDRESS

Perryman, Md.

Hdelsrace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1930

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\* B--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Starford*Village or City *Aberdeen* (No. \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATH

03028

Registration Dist. No. *181*

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME *Linnie Nora Holloway*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>married</i>
------------------------	---------------------------------	---

6 DATE OF BIRTH <i>April 28, 1872</i> (Month) (Day) (Year)
--

7 AGE <i>57 yrs. 11 mos. 0 ds.</i> IF LESS than 1 day ____ hrs. or ____ min.?
---

8 OCCUPATION (a) Trade, profession or particular kind of work <i>Housewife</i> (b) General nature of industry, business, or establishment in which employed (or employer)
--

9 BIRTHPLACE (State or country) <i>Maryland</i>
---

10 NAME OF FATHER <i>Gas. L. Bowman</i>
--

11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>
--

12 MAIDEN NAME OF MOTHER <i>Georgia Lovell</i>
---

13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Asah M. Holloway*(Address) *Aberdeen, Md.*15 Filed *Mar 29 1930* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <i>March 28, 1930</i> (Month) (Day) (Year)
---

17 I HEREBY CERTIFY, That I attended the deceased from *March 10, 1930* to *March 28, 1930*that I last saw her alive on *Mar 27, 1930*and that death occurred on the date stated above, at *4:13 PM*

The CAUSE OF DEATH \* was as follows:

*Cerebral Hemorrhage*

Contributory Secondary	(Duration) <i>0 yrs. 0 mos. 18 ds.</i> <i>Paralysis</i>
------------------------	--

(Signed) <i>A. H. H. H.</i>	(Duration) <i>0 yrs. 0 mos. 18 ds.</i>	M. D.
<i>Mar 29, 1930</i>	(Address) <i>Aberdeen</i>	

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL <i>Babers Cemetery</i>	DATE OF BURIAL <i>March 30 1930</i>
---	--

20 UNDERTAKER <i>Henry Tarrington</i>	ADDRESS <i>Aberdeen Md.</i>
--	--------------------------------



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Congressman, Architect, Locomotive engineer, Civil engineer, Stationery pressman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return Laborer, "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia* *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling brick—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

APR 7 1940  
BUREAU OF VITALS



WRITE

ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Darlington No. 90

2 FULL NAME Samuel S. Holloway

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St.        Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE Widower  
MARRIED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Aug. 14, 1849  
(Month) (Day) (Year)

7 AGE 80 yrs. 9 mos. 4 ds. IF LESS than  
1 day \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer) Farmer

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Hugh S. Holloway

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Hesterann Stump

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary R. Kirk

(Address) Conowingo, Md.

15 Filed May 18, 1920 M. R. Kirk  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 18, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 12, 1920 to May 18, 1920

that I last saw him alive on May 16, 1920

and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis

(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
Contributory Arteriosclerosis  
Secondary

(Signed) G. W. Stent M. D.  
5/18, 1920 (Address) Darlington, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_

Former or usual residence \_\_\_

19 PLACE OF BURIAL OR REMOVAL Friends Cem Darlington DATE OF BURIAL May 20, 1920

20 UNDERTAKER H. S. Bailey ADDRESS Darlington, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 6 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Abingdon (No. \_\_\_\_\_)2 FULL NAME Edward Joshua Hooker08083 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH August 20, 1865  
(Month) (Day) (Year)7 AGE 64 yrs. 10 mos. 22 ds. IF LESS than 1 day hrs. or min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Farming  
(b) General nature of industry business, or establishment in which employed or (employer) "9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Edward G. Hooker11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Elizabeth Horney13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julie Hooker  
(Address) Edgewood, Md.15 Filed July 14, 1930 Fred. Charlack  
local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH \_\_\_\_\_, 192\_\_\_\_  
July 12<sup>th</sup>, 1930 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 12<sup>th</sup> July, 1928 to date of death, 192\_\_\_\_  
that I last saw him alive on the 10<sup>th</sup> July, 1930,  
and that death occurred on the date stated above, at Fred's P.  
The CAUSE OF DEATH \* was as follows:Apoplexy - had several strokes - the last one just before his death  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) William S. Archer M. D.  
14<sup>th</sup> July, 1930 (Address) Belter Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Int. Barnum DATE OF BURIAL July 15, 193020 UNDERTAKER Howard K. McComas ADDRESS Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc.; Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WITHIN CORPORATE LIMITS OF

0507

STATE OF MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Harford

Registration Dist. No. 185

Village or City

Hdelsgrace

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Addie Hoopman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

March 18 1880  
(Month) (Day) (Year)

7 AGE

79 yrs. 9 mos. 14 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work housework.  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

J. Wesley Hoopman

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Louise Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. P. Walker

(Address)

Hdelsgrace Md.

15

Filed

Jan 4, 1930 Chas. J. Foley

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 2 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 15 1929 to Jan 2 1930

that I last saw him alive on Jan 12 1930

and that death occurred on the date stated above, at 29 m.

The CAUSE OF DEATH \* was as follows:

Atherosclerosis +  
Multiple Neuritis  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) F. D. Steiner M. D.

Jan 3 1930 (Address) Harford, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wesleyan Hospital Jan 4 1930

20 UNDERTAKER

ADDRESS

Birmingham Harford, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

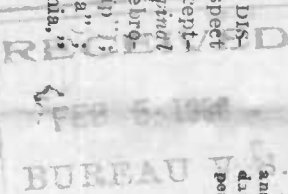
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A thorough check is essential and must be obtained before the certificate is permanently filed.





MARGIN RESERVED FOR BURIAL  
WRITE PERMIT, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u> WITHIN CORPORATE LIMITS OF <u>742</u>			13850 STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Harford</u> (No. <u>662</u> <u>Green</u> St. <u>Ward</u> )			Registration Dist. No. <u>185</u>		
2 FULL NAME <u>Annie Mary Hopkins</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>	16 DATE OF DEATH <u>Nov 25, 1930</u>		
6 DATE OF BIRTH <u>Dec 31, 1851</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u>		
7 AGE <u>78</u> yrs. <u>10</u> mos. <u>24</u> ds. or <u>LESS</u> than 1 day hrs. min.?			that I last saw her alive on <u>Nov. 25, 1930</u>		
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)			and that death occurred on the date stated above, at <u>124 1/2</u> m.		
9 BIRTHPLACE (State or country) <u>Pa.</u>			The CAUSE OF DEATH * was as follows: <u>Cerebral Hemorrhage</u>		
10 NAME OF FATHER <u>George J. Hopkins</u>			Contributory Secondary (Duration) <u>3</u> yrs. <u>0</u> mos. <u>0</u> ds.		
11 BIRTHPLACE OF FATHER (State or country) <u>Pa.</u>			(Signed) <u>F. W. Steiner</u> M. D. <u>Nov 26, 1930</u> (Address) <u>Harford Green St</u>		
12 MAIDEN NAME OF MOTHER <u>Isabella McComming</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Pa.</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>M. Norman C. Hopkins</u> (Address) <u>662 Green St</u>			Where was disease contracted, if not at place of death? Former or usual residence		
15 Filed <u>Nov. 26 1930</u> <u>Charles J. Foley</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Rockers Cross</u>		
			DATE OF BURIAL <u>Nov 28, 1930</u>		
			20 UNDERTAKER <u>Madison Mitchell</u> ADDRESS <u>N. d. b.</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebral meningitis*; *Typhoid fever* (never "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicæmia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—occident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Baltimore

75-2

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

182

Village or City

Benson

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mary Ann Hopper

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 ~~SINGLE~~  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

March 15, 1862

(Month)

(Day)

(Year)

7 AGE

68 yrs. 7 mos. 28 ds.

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

Housewife

9 BIRTHPLACE  
(State or country)

Portsmouth Va.

10 NAME OF  
FATHER

Martin O'Brien

11 BIRTHPLACE  
OF FATHER  
(State or country)

Ireland

12 MAIDEN NAME  
OF MOTHER

Mary Joyce

13 BIRTHPLACE  
OF MOTHER  
(State or Country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Chas. E. Gross

(Address)

Benson Md.

15

Filed Nov. 11, 1920, O. E. Chambers

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 10, 1920

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Nov. 7, 1920, to Nov. 10, 1920.

that I last saw him alive on Nov. 9, 1920,

and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH \* was as follows:

Hemiplegia

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 3 ds.

Contributory  
Secondary

Hemiplegia

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 3 ds.

(Signed)

Upmiller &amp; Styling M. D.

11/10/20 (Address) Hall Street

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Cem. 11/12, 1920

20 UNDERTAKER

ADDRESS

Hornberger &amp; Gross Benson Md.



(Approved by U. S. Census and American Public Health Association.)

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bacillæmia*, *Staphylococcal pneumonia*, *Staphylococcal pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is peremptorily filed.



MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH

County Harford

66767 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

Village or City Darlington (No. 44)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Mrs. Fannie C. House

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Sept. 9, 1852  
(Month) (Day) (Year)

7 AGE 78 yrs. 9 mos. 6 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Harford Co. Md.

PARENTS  
10 NAME OF FATHER Silas Carr  
11 BIRTHPLACE OF FATHER (State or country) Harford Co. Md.  
12 MAIDEN NAME OF MOTHER Martha Carr  
13 BIRTHPLACE OF MOTHER (State or Country) Harford Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bleacher W. House  
(Address) Darlington Md.

15 Filed June 17, 1930 M. W. Thirk  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 1, 1930 to June 15, 1930  
that I last saw him alive on June 4, 1930  
and that death occurred on the date stated above, at 5:50 a. m.  
The CAUSE OF DEATH \* was as follows:

Myocarditis  
(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Carcinoma of stomach  
Secondary (Duration) 1 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) W. E. Gallin M. D.  
June 16, 1930 (Address) Darlington Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Pa. Houses Cemetery DATE OF BURIAL June 18, 1930

20 UNDERTAKER Carl Reynolds ADDRESS Quarigill Pa.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 2 1931  
BUREAU OF



MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Harford

WITHIN CORPORATE LIMITS

10475

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Harford (No. -----) Hospital -----

St. ----- Ward ----- (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup>FULL NAME John B. Howell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Sept 12, 1881  
(Month) (Day) (Year)

7 AGE 48 yrs. 11 mos. 28 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Switchboard Wiring Foreman  
(b) General nature of industry, business, or establishment in which employed or (employer) Ches Pot Tel Co of Balto City

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Lloyd Howell

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Lily May Morrison

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacques L Cronin  
(Address) 4002 S 4th St Brooklyn Md

15 Filed Sept 10 1930 Charles J Foley M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 9th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192,  
that I last saw him alive on 192,

and that death occurred on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH \* was as follows:

From Cerebral Hemorrhage  
came about in natural way while operating  
his car on Union Avenue Harford, Md  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Martin P. Foley, "Coroner" M. D.  
Sept. 9th 1930 (Address) Harford, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 10 minutes In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence Baltimore Md

19 PLACE OF BURIAL OR REMOVAL Woodlawn Cemetery Balto DATE OF BURIAL Sept 12, 1930

20 UNDERTAKER Paul Chenoweth ADDRESS Baltimore Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

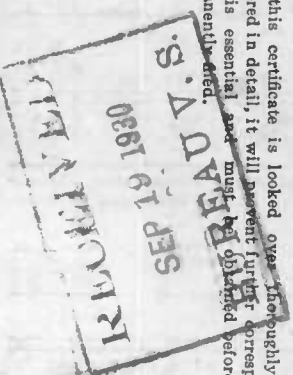
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never return "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BURNING  
WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# 1 PLACE OF DEATH

County Harford

WITHIN CORPORATE LIMITS OF

(197)

## STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Harri de Grace (No. Erie Street St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William Hudson

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Unknown 1 (Month) (Day) (Year)

7 AGE about 1 IF LESS than 1 day. hrs. 20 yrs. 25 mos. ds. or min.?

8 OCCUPATION (a) Trade, profession or particular kind of work Labor Railroading (b) General nature of industry business, or establishment in which employed or (employer) Railroad repair work

9 BIRTHPLACE (State or country) Dumfries Co., Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Henderson Colored (Address) Harri de Grace, Md.

15 Filed June 22 1930 Charles J. Foley, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 21<sup>st</sup> 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 21<sup>st</sup> 1930 to June 21<sup>st</sup> 1930, that I last saw him alive on June 21<sup>st</sup> 1930

and that death occurred on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH \* was as follows: Bullet wound, skull  
entering cranial hemorrhage  
Homicidal.

(Duration) 2-3 min yrs. mos. ds.

Contributory Secondary Hemorrhage

(Duration) 2-3 min yrs. mos. ds.

(Signed) Martin P. Foley - Coroner M.D. June 23 1930 (Address) Harri de Grace Md.

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Martinsville Va DATE OF BURIAL June 20 1930

20 UNDERTAKER Undertaker, Wilkerson of Martinsville Va ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. S.

JUL 3 1936







# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Lo. bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 6 1930  
BUREAU



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1 PLACE OF DEATH  
County Harford

Village or City Parrettsville (No. —)

2 FULL NAME H. S. Huff

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH June 29 1852  
(Month) (Day) (Year)

7 AGE 77 yrs. 7 mos. 29 ds. If LESS than 1 day \_\_\_ hrs. or \_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed or (employer) Farmer

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Abraham Huff

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Madcarborough

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. L. B. Ford  
(Address) Rockers, Md.

15 Filed Feb 28 1930 Thomas R. Brown  
Registrar

01732

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 183

St. — Ward — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 10 1930 to Feb 26 1930, that I last saw him alive on Feb 26 1930

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH \* was as follows:  
Organic Heart disease

Contributory Secondary (Duration) 1 yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) Charles W. Gorman M. D.  
Feb 28 1930 (Address) State B. Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Ascension Cem. DATE OF BURIAL March 2, 1930

20 UNDERTAKER H. S. Bailey ADDRESS Harlington, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAR 4 1930

BU



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<sup>1</sup>PLACE OF DEATH  
County Harford

6508

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 181

Village or City Near Hopewell md

(No.)

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup>FULL NAME Amos Hall Hughes

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH July 9 1858

(Month) (Day) (Year)

7 AGE 71 yrs. 5 mos. 26 ds. or IF LESS than 1 day hrs. or min.

8 OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed or (employer) Maryland

9 BIRTHPLACE (State or country) Amos Hollis Hughes

10 NAME OF FATHER md

11 BIRTHPLACE OF FATHER (State or country) Hanna Adams

12 MAIDEN NAME OF MOTHER md

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant) Mrs. Elizabeth J. Hughes

(Address) Warde Lane Md Route #2

15 Filed Jan 7 1930

Benjamin B. Knight Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 5 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1920 to Jan 5 1930

that I last saw him alive on Jan. 1 1930

and that death occurred on the date stated above, at 2.45 A.M.

The CAUSE OF DEATH \* was as follows:

Carcinoma of Liver

(Duration) 10 yrs. mos. ds.

Contributory  
Secondary

(Duration) 10 yrs. mos. ds.

(Signed) W.C. Gallion M. D.

Jan. 5 1930 (Address) Darlington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 10 yrs. mos. ds. In the State 10 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockrun Cove Jan 8 1930

20 UNDERTAKER

ADDRESS

Madison Mitchell Warde Lane



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

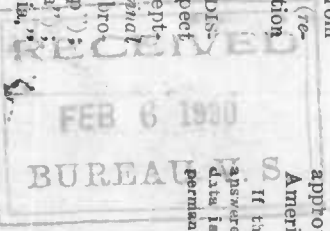
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesenteric Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Harford*

Village or City

*near State Hill*

(No. \_\_\_\_\_)

2 FULL NAME

*Walter B. Hutton*

05635

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *184*

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Single*

6 DATE OF BIRTH

*3* (Month)*7* (Day)*1880* (Year)

7 AGE

*50* yrs. *0* mos. *12* ds.IF LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Farmer*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*York County*

10 NAME OF FATHER

*Franklin Hutton*

11 BIRTHPLACE OF FATHER

*Leicester County*

12 MAIDEN NAME OF MOTHER

*Sandra Hutton*

13 BIRTHPLACE OF MOTHER

*Leicester County*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*W. B. Hutton*

(Address)

*Della Pa*

15

Filed

*May 21 1930**H. J. McNeill*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*May 19 1930*

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

*Saw him dead May 19, 1930*that I last saw him alive on *at 10 AM*, 1930.and that death occurred on the date stated above, at *7 A* M.

The CAUSE OF DEATH \* was as follows:

*apoplexy*

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

*A. E. Arthur*

M. D.

*May 21 1930* (Address) *Cardiff Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Stateville Cemetery**May 27 1930*

20 UNDERTAKER

ADDRESS

*John L. Morris Della Pa*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; . . . . . Shrapnelwound (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 6 1930

BUREAU OF



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Old Grace P.O. (No. 74a)

2 FULL NAME Eliza Jackson

WITHIN CORPORATE LIMITS OF

15067 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

St.: \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow  
(Write the word)

6 DATE OF BIRTH unknown 1 (Month) (Day) (Year)

7 AGE abt 60 yrs. — mos. — ds. If LESS than 1 day \_\_\_ hrs. or \_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work housework  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or Country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Dougherty  
(Address) Old Grace P.O.

15 Filed Dec. 18 1930 Charles J. Foley, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 14 1930 to Dec 16, 1930

that I last saw him alive on Dec 16, 1930,

and that death occurred on the date stated above, at 110 m.

The CAUSE OF DEATH \* was as follows:

Arteriosclerosis  
Apoplexy  
Stroke  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Contributory  
Secondary

(Signed) Charles J. Foley, M.D.  
12/17 1930 (Address) Old Grace P.O.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Green Spring Cem. DATE OF BURIAL Dec. 18, 1930

20 UNDERTAKER Remington & Son ADDRESS Old Grace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

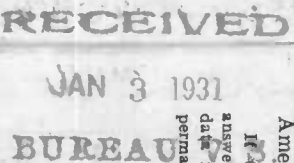
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rattling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

06769

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City Belair (No. 111 Alice Ave) St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Frank Jackson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 SINGLE, MARRIED, ~~WIDOWED,~~ OR DIVORCED Married  
(Write thousand)

6 DATE OF BIRTH June 1855  
(Month) (Day) (Year)

7 AGE 75 yrs. unkn mos. unkn ds. or min.?  
If LESS than 1 day. hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Janitor  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Harford Co Md.

10 NAME OF FATHER Henry Jackson

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Catharine Jones

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Catharine Jones

(Address) 111 Alice Ave

15 Filed June 16, 1930 V. E. Chambers  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 16<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 24<sup>th</sup>, 1930 to June 16<sup>th</sup>, 1930, that I last saw him alive on June 13<sup>th</sup>, 1930, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH \* was as follows:

Chronic interstitial nephritis

(Duration) unknown yrs. mos. ds.

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) A. F. Vane M. D. June 16<sup>th</sup>, 1930 (Address) Bel Air, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hedden Hill Cem 6/19, 1930

20 UNDERTAKER ADDRESS

Daniel Easton 916 Pa ave

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonium*, etc.; *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Brochopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inaptitude," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 3 1900  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hanford

Village or City Warlington (No. R. F. D.)

2 FULL NAME Sarah R G Jackson

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH 7 (Month) 1 (Day) 1869 (Year)

7 AGE 60 yrs. 5 mos. 4 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Peoria Illinois

10 NAME OF FATHER Henry Ganell

11 BIRTHPLACE OF FATHER (State or country) Peoria Illinois

12 MAIDEN NAME OF MOTHER Susan Brauman

13 BIRTHPLACE OF MOTHER (State or Country) Peoria Illinois

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Jackson

(Address) Warlington Md R F D

15 Filed Feb. 26 - 1923 H. J. Mc Nab Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 25, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1922 to Feb 25, 1923, that I last saw him alive on Feb 25, 1923, and that death occurred on the date stated above, at 9 A m.

The CAUSE OF DEATH \* was as follows:

Cancer of the stomach

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) A. E. Arthur M. D.

Feb 26, 1923 (Address) Carroll Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Broad Creek Cemetery Feb 28, 1923

20 UNDERTAKER ADDRESS

John L. Norris Delta Pa



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer or Plumber, Puglist, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state, occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Labor pneumonia, Bronchopneumonia ("Pneumonia,"*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.; Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory."

Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 8 1930  
BUREAU



WRITE HERE, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

09330

74a

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 184

Village or City Castleton (No.       )

St.        Ward        (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alveta H. James

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 ~~SINGLE.~~ Widow  
~~MARRIED.~~  
~~WIDOWED.~~  
~~OR DIVORCED~~  
(Write the word)

6 DATE OF BIRTH May 17 1851  
(Month) (Day) (Year)

7 AGE 79 yrs. 3 mos. 6 ds. or min. 2  
If LESS than 1 day, hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer)       

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Henry P. Farwood

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Annie P. Sampson

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. B. Smith

(Address) Darlington, Md.

15 Filed Aug 23 1930 M. V. Kirk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 23 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 1 1929 to Aug 23 1930, that I last saw her alive on Aug 21 1930 and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH \* was as follows:

Paralysis

Contributory Secondary Cerebral hemorrhage  
(Duration) 2 yrs.        mos.        ds.

(Signed) J. P. Burgess M. D.  
8-24-30 (Address) Darlington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death, yrs.        mos.        ds. In the State, yrs.        mos.        ds.

Where was disease contracted, if not at place of death?       

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL Darlington, Md. DATE OF BURIAL Aug 25 1930

20 UNDERTAKER H. S. Bailey ADDRESS Darlington, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Peeler," et., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BRANDING  
WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u>		113 10476 WITHIN CORPORATE LIMITS OF		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Shoreville Grace</u> (No. <u>612</u> <u>Water</u> St.)		Ward		Registration Dist. No. <u>185</u>	
2 FULL NAME <u>John Lee James</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Mar 20</u> 1930 (Month) (Day) (Year)					
7 AGE <u>6</u> yrs. <u>1</u> mos. <u>1</u> ds. or min. If LESS than 1 day hrs.					
OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Md</u>					
10 NAME OF FATHER <u>Louis James</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>					
12 MAIDEN NAME OF MOTHER <u>Clivior Henderson</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Louis James</u> (Address) <u>612 Water St</u>					
15 Filed <u>Sept 22 1930</u> <u>Charles J. Foley M.D.</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept 21</u> 1930 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 18</u> 1930 to <u>Sept 21</u> 1930. that I last saw him alive on <u>Sept 20</u> 1930. and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Rickets</u> <u>Enteric Colitis</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary (Signed) <u>W. S. Jones</u> M.D. <u>9-22</u> 1930 (Address) <u>Shoreville Grace Md</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Green Mount Cem</u>				DATE OF BURIAL <u>Sept 23</u> 1930	
20 UNDERTAKER <u>R. Madison Mitchell</u>				ADDRESS <u>Shoreville Grace Md</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scullery, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
OCT 6 1930  
BUREAU OF VITAL STATISTICS



MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

06770  
WITHIN CORPORATE LIMITS OF  
15-2

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Aberdeen (No. Thore de Grace Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Dr. Katherine Duff James

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH February 28, 1871  
(Month) (Day) (Year)

7 AGE 59 yrs. 4 mos. 1 ds. or LESS than 1 day \_\_\_ hrs. \_\_\_ min.?

8 OCCUPATION (a) Trade, profession or particular kind of work Osteopathic Dr. (b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Edward M. Duff

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Eliza J. Chie

13 BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lewis E. Smith  
(Address) Detroit Mich.

15 Filed July 1 1930 Charles J. Foley, M.D.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 17 1930 to June 29 1930, that I last saw him alive on June 29, 1930,

and that death occurred on the date stated above, at \_\_\_ m. The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis  
Hemiplegia  
Acute Nephritis  
(Duration) \_\_\_ yrs. 1 mos. \_\_\_ ds.

Contributory Cardiac Failure  
Secondary uremia  
(Duration) \_\_\_ yrs. \_\_\_ mos. 6 ds.

(Signed) Charles J. Foley M. D.  
July 1 1930 (Address) Harford

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Smith Chapel Cemetery DATE OF BURIAL July 1, 1930

20 UNDERTAKER Henry Tanning Sons ADDRESS Harford Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 3 1920  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

12500

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 180

Village or City Edgewood (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lina B. Janney

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH December 15, 1849  
(Month) (Day) (Year)

7 AGE 80 yrs. 9 mos. 23 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Teacher & Seamstress  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Cecil Co. Maryland

10 NAME OF FATHER Thomas Janney

11 BIRTHPLACE OF FATHER (State or country) Cecil Co. Maryland

12 MAIDEN NAME OF MOTHER Rachel Miriam Blake

13 BIRTHPLACE OF MOTHER (State or Country) Cecil Co. Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha M. Tyson  
(Address) Colona, Md.

15 Filed Oct 8 1930 Friedrich Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 8 - 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 11/150

The CAUSE OF DEATH \* was as follows:

Chronic Bronchitis

(Duration) 30 yrs. mos. ds.

Contributory  
Secondary

Myocardial Infarction

(Signed) Chas. R. R. M. D.  
Oct 8 1930 Address Edgewood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bayview, Cecil Co. Md. DATE OF BURIAL Oct 12 1930

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

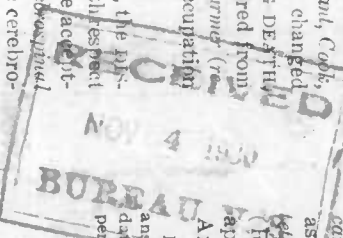
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, meningitis*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





W. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS OF

13852

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Harford

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Infant Jenkins (Male)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col.

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Nov 19, 1930  
(Month) (Day) (Year)

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
\_\_\_\_ yrs. \_\_\_\_ mos. 3 ds. or \_\_\_\_ min.?

## OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Harford

10 NAME OF FATHER

Richard Jenkins

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Caroline Jenkins

13 BIRTHPLACE OF MOTHER

(State or Country)

South Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Jenkins

(Address)

Harford

15

Filed

11/22 1930 Char. J. Folger  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 22, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Nov 22, 1930 to Nov 22, 1930

that I last saw him alive on Nov 22, 1930

and that death occurred on the date stated above, at 10.9 m.

The CAUSE OF DEATH \* was as follows:

Premature Birth

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 3 ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 3 ds.

(Signed)

Charles J. Folger, M. D.

11/22 1930 (Address) Harford

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

County Cemetery 11/23/30

20 UNDERTAKER

ADDRESS

John Jenkins Harford



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1930

RECEIVED



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1 PLACE OF DEATH  
County Hanford

Village or City Darlington (No. \_\_\_\_\_)

2 FULL NAME Lena Jennings

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St.: \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME in- stead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) wid

6 DATE OF BIRTH Sept 23, 1930  
(Month) (Day) (Year)

7 AGE 73 yrs. 11 mos. 23 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) N. C.

10 NAME OF FATHER Franklin Duncan

11 BIRTHPLACE OF FATHER (State or country) N. C.

12 MAIDEN NAME OF MOTHER Wolfe

13 BIRTHPLACE OF MOTHER (State or Country) N. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Check  
(Address) Darlington Md

15 Filed Sept 15 1930 M. W. Kirk  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 2 1930 to Sept 14, 1930

that I last saw him alive on Sept 13, 1930,

and that death occurred on the date stated above, at 4 A m.  
The CAUSE OF DEATH \* was as follows:

Acute Enteritis  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 5 ds.

Contributory  
Secondary

(Signed) Willard P. Hudson M. D.  
Sept 15 1930 (Address) Forest Hill Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For hospitals, institutions, transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Elkin N. C. DATE OF BURIAL Sept 16, 1930

20 UNDERTAKER H. S. Bailey ADDRESS Darlington Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

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OCT 6 1930

BUREAU



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## 1 PLACE OF DEATH

County

Harford

Village or City

Dublin

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ellie May Jennings

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

May 31, 1899

(Month)

(Day)

(Year)

7 AGE

31 yrs. 9 mos. 1 ds.

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Va

10 NAME OF FATHER

Abe Anderson

11 BIRTHPLACE OF FATHER

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Susan Spurling

13 BIRTHPLACE OF MOTHER

(State or Country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fonce Jennings  
Street Md

(Address)

15

Filed

March 1, 1930 M. W. Rich

Registrar

16 DATE OF DEATH

March 1, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 1, 1930 to March 1, 1930.

that I last saw her alive on Feb 27, 1930.

and that death occurred on the date stated above, at 6 AM.

The CAUSE OF DEATH \* was as follows:

Carcinoma of Stomach

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Willard P. Hudson M. D.

March 2, 1930 (Address) 404 S. Hill, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Mt Zion Cem  
H. S. Bailey

DATE OF BURIAL

March 3, 1930

20 UNDERTAKER

ADDRESS

Darlington Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Senile," "Thrombosis," "Hæmorrhage," "Hæmaturia," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
BUREAU V. S.



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1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS 01734

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Harred Grace

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ben. John En

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE,

MARRIED, UNKNOWN, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

Unknown

7 AGE

About 55 years

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Unknown

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nelson Mcray

(Address)

Harred Grace Md.

15

Filed

Feb. 15, 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 14, 1930

17 I HEREBY CERTIFY, That I attended the deceased from

Jan 4, 1930 to Jan 14, 1930.

that I last saw him alive on

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH \* was as follows:

Chronic Atherosclerosis  
Fibrosclerosis

Contributory Secondary Cardiac Failure

(Signed) J. N. Seigrist, M. D.  
Jan 14, 1930 (Address) Harred Grace Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St. James Cem.

DATE OF BURIAL

Feb. 14, 1930

20 UNDERTAKER

Madison Mitchell Harred Grace

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "roup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as *Asthenia*, "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

MAR 6 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Pleasantville (No. \_\_\_\_\_)2 FULL NAME Carrie Regina Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>negro</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Infant</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH  
Sept 12<sup>th</sup>, 1928  
(Month) (Day) (Year)7 AGE  
1 yrs. 2 mos. 26 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Ind10 NAME OF FATHER Henry Johnson11 BIRTHPLACE OF FATHER (State or country) W. Va12 MAIDEN NAME OF MOTHER Carrie Hurd13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Johnson(Address) Laurelton, Ind15 Filed Dec. 9, 1930 W. E. Chambers  
Registrar

15068

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 182

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 7, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Dec 6, 1930 to Dec 7, 1930.that I last saw her alive on Dec 6, 1930and that death occurred on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH \* was as follows:

Septic Encephalitis(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 15 ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Willard B. Hudson M. D.  
Dec 7, 1930 (Address) Forest Hill Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Tabernack Ceme. Col. Dec. 10, 193020 UNDERTAKER Benson ADDRESS BensonHornbarger & Gross



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

JAN 3 1931

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford,

WITHIN CORPORATE LIMITS OF

0509

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185

Village or City Hdelsrace (No. Hospital St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
2 FULL NAME Charles Johnson,

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Unknown

6 DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)

7 AGE abt. 49 yrs. - mos. - ds. or LESS than 1 day hrs. or min.?

8 OCCUPATION (a) Trade, profession or particular kind of work labor (b) General nature of industry business, or establishment in which employed or (employer) -

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Kellie Jones

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hdelsrace Hospital  
(Address) Hdelsrace Md.

15 Filed Jan. 29 1930 Chas. J. Foley M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan, 1930 (Month) 26 (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1, 1930 to Jan 26, 1930. that I last saw him alive on Jan 25, 1930.

and that death occurred on the date stated above, at 11 m. The CAUSE OF DEATH \* was as follows:

Cardiac Decomposition

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) W. J. Jones M. D.  
1/29, 1930 (Address) Hdelsrace Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1

19 PLACE OF BURIAL OR REMOVAL County Benn. DATE OF BURIAL Jan. 29, 1930

20 UNDERTAKER Pennington ADDRESS Hdelsrace Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

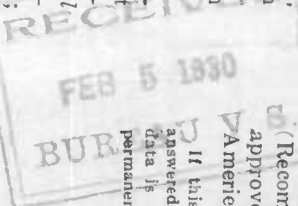
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Airedier, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





MARGIN RESERVED FOR RECORDING  
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County Harford

0850

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Harrods Grace (No. \_\_\_\_\_)

St.: \_\_\_\_\_ Ward: \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME George Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Oct.261869

(Month):

(Day):

(Year)

7 AGE

60

yrs.

8

mos.

18

ds.

If LESS than

1 day \_\_\_\_\_ hrs.

or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Book Keeping

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE

OF FATHER

(State or country)

Same

12 MAIDEN NAME

OF MOTHER

Unknown

13 BIRTHPLACE

OF MOTHER

(State or Country)

Same

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Harrods Grace Md

15

Filed

July 13, 1930Chas. J. Foley, M.D.

Registrar

16 DATE OF DEATH

7-131930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Nov 1929

192

to

July 131930

that I last saw him alive on

July 131930

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

[Signature]

M. D.

7-13

192

(Address)

Harrods Grace Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rock Spring Cem.July 16, 1930

20 UNDERTAKER

ADDRESS

Forbinger & Sons Benson

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sorecoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 5 1930  
BUREAU V S



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Emmorton (No. \_\_\_\_\_)

2 FULL NAME John Rubin Johnson

6510

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Unknown, 1869  
(Month) (Day) (Year)

7 AGE 61 yrs. Unknown mos. Unknown ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work farm laborer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER George Johnson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) May Johnson  
(Address) Gettysburg Rd

15 Filed Jan 30 1930 M. E. Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 5 1930 to Jan 29, 1930  
that I last saw him alive on Jan 25, 1930

and that death occurred on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH \* was as follows: Patient either vomited or coughed up several quarts of blood, and was found dead in the morning. Swollen.

hemorrhage from lungs:  
non-tubercular. (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Chronic Myocarditis  
following chronic pneumonia. (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Charles E. Edwards M. D.  
Jan 29, 1930 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Carmel M.P. Cemetery DATE OF BURIAL Jan 31, 1930

20 UNDERTAKER Emmorton Md. ADDRESS Benson Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Harford*

WITHIN CORPORATE LIMITS

Village or City

*Harvade Grace Hospital*

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Joseph Lee Johnson*Registration Dist. No. *185*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Single*

6 DATE OF BIRTH

*December 15, 1926*  
(Month) (Day) (Year)

7 AGE

*4* yrs. *1* mos. *15* ds. or min.?

If LESS than 1 day hrs. min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Maryland*

10 NAME OF FATHER

*James Johnson*

11 BIRTHPLACE OF FATHER

*Virginia*

12 MAIDEN NAME OF MOTHER

*Vertie Grace*

13 BIRTHPLACE OF MOTHER

*North Carolina*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mr James Johnson*

(Address)

*Chesden Rd*

15

Filed

*Dec. 1*

192

*Charles J. Foley M.D.*

Registrar

13853

(175)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Nov 30, 1930*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*Nov 29, 1930* to *Nov 30, 1930*that I last saw him alive on *Nov 30, 1930*and that death occurred on the date stated above, at *6:30 a.m.*

The CAUSE OF DEATH \* was as follows:

*Unable to determine the food causing poisoning.**Acute hepatitis**Probably Food Poisoning*(Duration) *six days* yrs. mos. ds.Contributory  
Secondary*Cardiac Failure*

(Signed)

*Charles J. Foley M.D.**Dec. 1, 1930* (Address) *Harvade Grace Hos.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Bahus Cemetery**Dec. 2, 1930*

20 UNDERTAKER

ADDRESS

*Henry Tarrington Chesden Rd.*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

DEC 5 1930

BUREAU



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1 PLACE OF DEATH  
County Hagerston

Village or City Perryman (No. \_\_\_\_\_)

13854 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Ocho Howland Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH June 6, 1864  
(Month) (Day) (Year)

7 AGE 66 yrs. 5 mos. 5 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Merchant.  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland.

10 NAME OF FATHER Samuel McJohnson

11 BIRTHPLACE OF FATHER (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Casslyn Howland

13 BIRTHPLACE OF MOTHER (State or Country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elta Helen Johnson  
(Address) Perryman Md.

15 Filed Nov 17 1920 O. C. Michael  
Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 11, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 27 1920 to Nov 11 1920  
that I last saw him alive on Nov 11 1920

and that death occurred on the date stated above, at 2:20 A. m.  
The CAUSE OF DEATH \* was as follows:

Robert Pneumonia

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) St. D. O'Leary M. D.  
Nov 11 1920 (Address) Perryman

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spesutia Cemetery Nov 13, 1920

20 UNDERTAKER

ADDRESS

Henry Tanning Sons 4 Gordon Rd



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			STATE OF MARYLAND	
County <u>Harford</u>			CERTIFICATE OF DEATH	
Village or City <u>Hdels Grace</u> (No. <u>188-C</u> )			St. <u>Hospital</u>	Ward <u>185</u>
2 FULL NAME <u>Sidney A. Johnson Jr.</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)		
6 DATE OF BIRTH <u>June 7 - 1907</u> (Month) (Day) (Year)				
7 AGE <u>22</u> yrs. <u>9</u> mos. <u>6</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Electrical</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>work</u>				
9 BIRTHPLACE (State or country) <u>North Carolina</u>				
10 NAME OF FATHER <u>Sidney A. Johnson</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>North Carolina</u>				
12 MAIDEN NAME OF MOTHER <u>Lillian Byrd</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>North Carolina</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Sidney A. Johnson Jr.</u> (Address) <u>Hillsborough N.C.</u>				
15 Filed <u>Mar. 15, 1930</u> <u>Charles J. Foley, M.D.</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>March 15<sup>th</sup>, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw him alive on <u>192</u> , and that death occurred on the date stated above, at <u>2<sup>nd</sup> A</u> m.				
The CAUSE OF DEATH * was as follows: <u>Fractured Skull, Contusion of brain, Intercranial Hemorrhage, caused by being accidentally hit by Automobile in Parfitt, Md.</u> (Duration) <u>4</u> hrs. <u>15</u> mos. <u>6</u> ds.				
Contributory Secondary <u>Hemorrhage</u> (Duration) <u>4</u> hrs. <u>15</u> mos. <u>6</u> ds.				
(Signed) <u>Martin P. Foley, Coroner</u> M. D. <u>March 15<sup>th</sup>, 1930</u> (Address) <u>Harford, Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) <u>4 hours</u> At place of death <u>4</u> hrs. <u>15</u> mos. <u>6</u> ds. In the State <u>4</u> hrs. <u>15</u> mos. <u>6</u> ds.				
Where was disease contracted, if not at place of death? <u>Accident</u>				
Former or usual residence <u>Hillsborough North Carolina</u>				
19 PLACE OF BURIAL OR REMOVAL <u>Hillsborough N.C. Md.</u> DATE OF BURIAL <u>17, 1930</u>				
20 UNDERTAKER - <u>Remingtonson Hdels Grace Md.</u> ADDRESS				



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicæmia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
APR 6 1921  
BUREAU V. S.



MARGIN RESERVED FOR BURIAL  
WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			05636		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			(89)		Registration Dist. No. <u>181</u>	
Village or City <u>Churchville Md</u>			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John G. Johnston</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widower</u>				
6 DATE OF BIRTH <u>August 30, 1873</u> (Month) (Day) (Year)						
7 AGE <u>56 yrs. 9 mos. - ds.</u> If LESS than 1 day ____ hrs. or ____ min.?						
OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Virginia</u>						
PARENTS	10 NAME OF FATHER <u>Chas. R. Johnston</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>					
	12 MAIDEN NAME OF MOTHER <u>Jane L. Goodpasture</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Virginia</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Miss Mildred Johnston</u> (Address) <u>Bel Air Md. R. F. D. #1</u>						
15 Filed <u>May 26 1923</u> <u>O. B. McNeal</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>May 24, 1923</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>May 15, 1923</u> to <u>May 24, 1923</u> that I last saw him alive on <u>May 21, 1923</u> and that death occurred on the date stated above, at <u>12:15 P.M.</u> The CAUSE OF DEATH * was as follows: <u>Angina Pectoris</u> (Duration) ____ yrs. ____ mos. ____ ds. Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>W. C. Hallion</u> M. D. <u>May 24, 1923</u> (Address) <u>Washington</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Churchville Cemetery</u> DATE OF BURIAL <u>May 26, 1923</u>						
20 UNDERTAKER <u>Henry Tarring &amp; Sons</u> ADDRESS <u>Churchville Md</u>						



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Cool mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 4 1930  
BUREAU V. S.







# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archivist, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worker on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same, accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Groaty"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. 3



MARGIN RESERVED FOR WRITING. ANY WRITING IN THIS MARGIN IS A PERMANENT RECORD.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City County Home No. Bel Air Md

2 FULL NAME Benz. Jones

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Unknown 1 \_\_\_\_\_  
(Month) (Day) (Year)

7 AGE About 80 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clark Fitzpatrick

(Address) Bel Air Md

15 Filed JUN 30 1930 Virginia E Chambers  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 29, 1930 to June 29, 1930

that I last saw him alive on June 29, 1930

and that death occurred on the date stated above, at 2:30 P.M.  
The CAUSE OF DEATH \* was as follows:

Apoplexy

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) Chas. Richardson (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
June 30, 1930 Address 13 Cedar Rd M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

County Home

June 30, 1930

20 UNDER TAKER

ADDRESS

Dean & Foster

Bel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The maternal worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 3 1900  
BUREAU OF



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Starford

WITHIN CORPORATE LIMITS OF

0511 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Harvard No. 185

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Clinton M. Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH June 24, 1866  
(Month) (Day) (Year)

7 AGE 62 yrs. 6 mos. 14 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Insurance Agent  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James H. Jones

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Botts

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Nuptle Jones

(Address) Harvard

15 Filed 11/11/1920 Registrar Charles J. Foley

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 20, 1929 to Jan 8, 1930, that I last saw him alive on Jan 8, 1930

and that death occurred on the date stated above, at 8 A.M.  
The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis  
Inter Cranial Hemorrhage  
Thrombosis  
(Duration) yrs. 7 mos. ds.

Contributory Secondary Cerebral Failure

(Duration) yrs. 3 mos. ds.  
(Signed) Charles J. Foley M. D.  
11/11/1920 (Address) Harvard

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Angel Hill Bur. Jan 2, 1930

20 UNDERTAKER ADDRESS Birmingham Olds



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Whiteford (No. \_\_\_\_\_)

2 FULL NAME Florence May Jones

15069

(145-2)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 187

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE Married  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Nov. 24, 1904  
(Month) (Day) (Year)

7 AGE 26 yrs. - 17 ds. or 1 day 17 hrs. 5 min.?  
If LESS than

8 OCCUPATION  
(a) Trade, profession or particular kind of work At home  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER John W. Daughton

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Kate Price

13 BIRTHPLACE OF MOTHER (State or country) Ta

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henny W. Jones

(Address) Whiteford Md

15 Filed Dec 13 1930 H. J. S. Mcnabb  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 11, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the decedent from Nov 10 1930 to Dec 11 1930  
that I last saw him alive on Nov 10 1930, 1930,  
and that death occurred on the date stated above, at 6 P m.

The CAUSE OF DEATH \* was as follows:

Stomachic poisoning  
due to food  
refined  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) H. J. S. Mcnabb M. D.  
Dec 11 1930 (Address) Cardiff Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Stated Edge County DATE OF BURIAL Dec 14, 1930

20 UNDERTAKER Deo Z. Lee ADDRESS Dallas Ta



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Scarlatina* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH					06772		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>					(49)		Registration Dist. No. <u>183</u>	
Village or City <u>Chrome Hill</u> (No. <u>49</u> )					St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>James Andrew Jones</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, <u>married</u> , WIDOWED OR DIVORCED (Write the word)						
6 DATE OF BIRTH <u>May 28</u> , 18 <u>61</u> (Month) (Day) (Year)								
7 AGE <u>69</u> yrs. <u>0</u> mos. <u>22</u> ds. or min. ? If LESS than 1 day... hrs.								
8 OCCUPATION (a) Trade, profession or particular kind of work. <u>Farmer</u> (b) General nature of industry business, or establishment in which employed or (employer) _____								
9 BIRTHPLACE (State or country) <u>North Carolina</u>								
10 NAME OF FATHER <u>Ambrose Jones</u>								
11 BIRTHPLACE OF FATHER (State or country) <u>North Carolina</u>								
12 MAIDEN NAME OF MOTHER <u>Sarah James</u>								
13 BIRTHPLACE OF MOTHER (State or country) <u>North Carolina</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Susan Jones</u> (Address) <u>Rocke md</u>								
15 Filed <u>June 22 1930</u> <u>Thomas R. Brown</u> Registrar								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>June 20</u> , 19 <u>30</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from <u>May 1</u> , 19 <u>30</u> , to <u>June 20</u> , 19 <u>30</u> , that I last saw him alive on <u>June 20</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>9:30 PM</u> , The CAUSE OF DEATH was as follows: <u>Cancer of Prostate Gland</u>								
(Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> da.								
Contributory Secondary _____								
(Duration) _____ yrs. _____ mos. _____ da.								
(Signed) <u>Charles H. Garrow</u> M.D. <u>June 21 1930</u> (Address) <u>Sheet Pt. md.</u>								
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death _____ yrs. _____ mos. _____ da. In the State, _____ yrs. _____ mos. _____ da.								
Where was disease contracted, if not at place of death? _____								
Former or usual residence, _____								
19 PLACE OF BURIAL OR REMOVAL <u>Centre Cemetery</u> DATE OF BURIAL <u>June 22 1930</u>								
20 UNDERTAKER <u>E. G. Smith &amp; Son</u> ADDRESS <u>Janetville md</u>								



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housewife*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPARTAL septicæmia," "PERIPARTAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 3 1930

BUREAU V



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford05637 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 184Village or City Whiteford (No. 74a)

St.: \_\_\_\_\_ Ward: \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME James Shaw Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

3171864

(Month)

(Day)

(Year)

7 AGE

66119ds.

If LESS than

1 day \_\_\_\_\_ hrs.

or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Harford Co. Md

10 NAME OF

FATHER

Benjamin Jones

11 BIRTHPLACE

OF FATHER

Whiteford

(State or country)

Harford Co. Md

12 MAIDEN NAME

OF MOTHER

Rachael Right

13 BIRTHPLACE

OF MOTHER

Harford Co. Md

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs James Shaw Jones

(Address)

Whiteford Md

15 Filed

May 7 - 1930H. J. D. McNeill

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 41930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Apr 1st 1928 to May 1st 1929that I last saw him alive on May 1st 1929and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH \* was as follows:

Right Hemiplegia  
followed by apoplexy  
which caused intracerebral  
death. (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory

Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

N. E. Arthur

M. D.

May 6 1929 (Address) Cardiff. Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

State Ridge cemetery May 7 1930

20 UNDERTAKER

ADDRESS

John L Morris Md

if more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *sc. shopteumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marsmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by moving train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the date is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 6 1910

BUREAU



MARGIN RESERVED FOR BINDING

WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS OF 01735

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Hawthorne Grace

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Martha J. Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

March 20, 1872

(Month)

(Day)

(Year)

7 AGE

57 yrs. 10 mos. 15 ds.

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Housework

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

James T. Knight

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Martha J.

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leonard Jones

(Address)

457 Green St. Hawthorne Grace

15

Filed

2/5

1930

Charles J. Foley

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 4, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 1, 1929 to Feb 4, 1930.

that I last saw her alive on Feb 4, 1930.

and that death occurred on the date stated above, at 9:41 m.

The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis

Hemiplegia

Hypostatic Pneumonia

(Duration) yrs. 4 mos. ds.

Contributory Secondary

Cardiac Failure

(Duration) yrs. 3 mos. ds.

(Signed)

Charles J. Foley M.D.

215 1930 (Address) Hawthorne Grace

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hawthorne Grace

Feb. 7, 1930

20 UNDERTAKER

ADDRESS

H. S. Bailey

Hawthorne Grace Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 2 1930  
BUREAU V. S.



MARGIN RESERVED FOR BANDING

WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

Village or City

Whiteford

2 FULL NAME

Harry O Keese

13855

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Oct 25, 1879

(Month)

(Day)

(Year)

7 AGE

51 yrs. 1 mos. 2 ds.

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Pa.

10 NAME OF FATHER

Henry Keese

11 BIRTHPLACE OF FATHER

(State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Emma F. Keese

13 BIRTHPLACE OF MOTHER

(State or country)

Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mable B. Keese

(Address)

Whiteford Md

15

Filed Nov. 28, 1923 J. S. McCall

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 27, 1923

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Nov 1, 1923 to Nov 26, 1923

that I last saw him alive on Nov 26, 1923

and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH \* was as follows:

Cerebral

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Nov 27, 1923 (Address) J. S. McCall

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Whiteford County Nov 29, 1923

20 UNDERTAKER

ADDRESS

J. S. McCall Delta Pa



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Chloremia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL *septicaemia*," "PERIPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

DEC 4 1930

BUREAU



WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Madonna (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2 FULL NAME Boby Keller

0512 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 18.2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE wh. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Jan 16, 1930  
(Month) (Day) (Year)

7 AGE Infant If LESS than 1 day \_\_\_\_ hrs. or 15 min.?  
\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Harding Keller

11 BIRTHPLACE OF FATHER (State or country) D.C.

12 MAIDEN NAME OF MOTHER Mabel Jackson

13 BIRTHPLACE OF MOTHER (State or Country) D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Chas. Kohuter

(Address) Saratoga ville

15 Filed Jan 16 1930 N.E. Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 16 1930 to Jan 16 1930.

that I last saw him alive on Jan 16, 1930.

and that death occurred on the date stated above, at 1:00 P.m.  
The CAUSE OF DEATH \* was as follows:

Asphyxiation: probably due to pro-  
longed pressure of the infant's head against a  
rigid perineum in the presence of violent contractions of the uterus.  
Contributory Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Willard B. Hudson M. D.  
Jan 16 1930 (Address) 701 1/2 Hill, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Madonna DATE OF BURIAL Jan 17, 1930

20 UNDERTAKER Harding Keller ADDRESS Madonna

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 4 1930

BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Baltimore

WITHIN CORPORATE LIMITS OF

05638

159-7

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 125

Village or City Baltimore (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Edgar Russell Kelly

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

May 28, 1930  
(Month) (Day) (Year)

7 AGE

yrs. \_\_\_\_\_ mos. 1 ds. or \_\_\_\_\_ min.?

If LESS than  
1 day \_\_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Baltimore

10 NAME OF  
FATHER

Edgar R Kelly

11 BIRTHPLACE  
OF FATHER  
(State or country)

Baltimore

12 MAIDEN NAME  
OF MOTHER

Ruth M Lowe

13 BIRTHPLACE  
OF MOTHER  
(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Holeman road

15

Filed

May 29, 1930 Chas. J. Foley, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 28, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
May 28, 1930 to May 29, 1930

that I last saw him alive on May 28, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Engel's Disease  
Myelofibrosis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary

(Signed)

F. J. Steiner M. D.  
May 29, 1930 (Address) Holeman road

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Angel Hill Cemetery  
Baltimore

DATE OF BURIAL

May 29, 1930

20 UNDERTAKER

Baltimore

ADDRESS

Holeman road



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc.; *Cerebrum, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 5 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			WITHIN CORPORATE LIMITS OF		6513		STATE OF MARYLAND		CERTIFICATE OF DEATH		
County <u>Harre Harford</u>					(84)		Registration Dist. No. <u>185</u>				
Village or City <u>Harre de Grace</u> (No. <u>Hospita</u> )			St.:		Ward:		(If death occurred in a hospital or institution, give its NAME instead of street and number.)				
2 FULL NAME <u>Gladys Edith Kelly</u>											
PERSONAL AND STATISTICAL PARTICULARS											
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>									
6 DATE OF BIRTH <u>April 24, 1920</u> (Month) (Day) (Year)											
7 AGE <u>9 yrs. 9 mos. 7 ds.</u> If LESS than 1 day, hrs. or min.?											
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)			<u>School</u>								
9 BIRTHPLACE (State or country)			<u>Md.</u>								
10 NAME OF FATHER			<u>Tom Lewis Kelly</u>								
11 BIRTHPLACE OF FATHER (State or country)			<u>Pa.</u>								
12 MAIDEN NAME OF MOTHER			<u>Florence Edith Flowers</u>								
13 BIRTHPLACE OF MOTHER (State or Country)			<u>Md.</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Florence E. Kelly</u> (Address) <u>Harre de Grace Md.</u>											
15 Filed <u>Feb. 3, 1930</u> <u>Blas J. Foley, M.D.</u> Registrar											
MEDICAL CERTIFICATE OF DEATH											
16 DATE OF DEATH <u>Jan 31, 1930</u> (Month) (Day) (Year)											
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 26, 1930</u> to <u>Jan 31, 1930</u> . that I last saw him alive on <u>Jan 31, 1930</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Chorea - Possible Cerebral tumor. No autopsy made. no further information.</u> (Duration) <u>2 yrs. 9 mos.</u> ds.											
Contributory Secondary (Signed) <u>R. Lewis</u> M. D. <u>Feb 2, 1930</u> (Address) <u>Harre de Grace Md.</u>											
*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.											
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____											
19 PLACE OF BURIAL OR REMOVAL <u>Funerary Home</u>											
DATE OF BURIAL <u>Feb 3, 1930</u>											
20 UNDERTAKER <u>H. Madison Mitchell</u>											
ADDRESS <u>Harre de Grace Md.</u>											



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Typhoid"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 5 1900

BUREAU 70



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1 PLACE OF DEATH

County

*Hanford*

WITHIN CORPORATE LIMITS OF (202)

09331

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

185

Village or City *Hdelsrace* (No. \_\_\_\_\_)*Hospital*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Sarah E. Kelly*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female white*

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*married*

6 DATE OF BIRTH

*September 4, 1884*  
(Month) (Day) (Year)

7 AGE

*45 yrs. 11 mos. 16 ds.* or min.?

If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Pennsylvania*

10 NAME OF FATHER

*Michael Sweeney*

11 BIRTHPLACE OF FATHER

(State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Mary Moran*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Pennsylvania*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Joseph Kelly*

(Address)

*Howard Green Rd*

15 Filed

*Aug. 22, 1930* *Chas. J. Foley, M.D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Aug 21, 1930*  
(Month) (Day) (Year)17 I HEREBY CERTIFY That I attended the deceased from *Aug 20, 1930* to *Aug 21, 1930*that I last saw her alive on *Aug 21, 1930*and that death occurred on the date stated above, at *9 P* m.

The CAUSE OF DEATH \* was as follows:

*Septicaemia*

Contributory Secondary

*Infectious cut m*  
*thigh*  
(Duration) yrs. mos. ds.

(Signed)

*J. L. Thompson* M. D.  
*Aug 22, 1930* (Address) *Howard Green Rd*

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Holy Cross Cem, Pa, Aug. 25, 1930.*

20 UNDERTAKER

ADDRESS

*Pennington House Hdelsrace, Md.*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Truemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. S.



MARGIN RESERVED FOR BINDING

WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified--Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Whiteford (No. \_\_\_\_\_)

2 FULL NAME Walter P. Kennedy

02122

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE Single  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Nov 15 1929  
(Month) (Day) (Year)

7 AGE 2 yrs. 2 mos. 28 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Phillip C. Kennedy

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Mildred Harmon

13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Philip C Kennedy

(Address) Whiteford Ind

15 Filed Feb 14 1930 J. D. McCreath  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 13 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 13 1930 to Feb 12 1930

that I last saw him alive on Feb 12 1930

and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH \* was as follows:

Whooping cough followed by Bacterial Pneumonia  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) W. E. Arthur M. D.  
Feb 13 1930 (Address) Cardiff Ind

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL State of Md DATE OF BURIAL Feb 15 1930

20 UNDERTAKER W. H. Hall ADDRESS State of Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *shopteumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Iatinition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAR 6 1930

BUREAU



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford15639 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 183

(129)

Village or City Jarrettsville (No.     , St.      Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Alverda King

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>
------------------------	---------------------------------	--

6 DATE OF BIRTH  
April 4 1865, I. (Month) (Day) (Year)7 AGE  
65 yrs. 1 mos. 13 ds. or      min. ?  
If LESS than 1 day....hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \*\*\*\*\*9 BIRTHPLACE  
(State or country) Harford Co., Md.

PARENTS	10 NAME OF FATHER <u>Nathaniel B. Hesps</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>Harford Co., Md.</u>
	12 MAIDEN NAME OF MOTHER <u>Rebecca Strawbridge</u>
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles M. King(Address) Jarrettsville, Md.15 Filed May 18 1930 Thomas P. Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
May 17, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
May 12 1928, to May 16 1930,  
that I last saw him alive on May 16 1930,  
and that death occurred on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH was as follows:

Bright's Disease.Contributory  
Secondary  
(Duration) 2 yrs. 5 mos.      ds.  
(Duration)      yrs.      mos.      ds.(Signed) H. F. Bradley M. D.May 15 1930 (Address) Jarrettsville, Md.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?

Former or usual residence     

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Jarrettsville, Cem. May 19 193020 UNDERTAKER ADDRESS  
E. G. Kurtz & Son Jarrettsville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.) If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 5 1930

BUREAU



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Harford

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

182

Village or City

Sandy Hook

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

China King

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Feb. 28, 1926

(Month)

(Day)

(Year)

7 AGE

4 yrs. 6 mos. 23 ds.

If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

None

9 BIRTHPLACE (State or country)

North Carolina

10 NAME OF FATHER

Joseph King

11 BIRTHPLACE OF FATHER

(State or country)

N. C.

12 MAIDEN NAME OF MOTHER

Mary Billings

13 BIRTHPLACE OF MOTHER

(State or Country)

N. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Joseph King

(Address)

Bel-air, Md.

15

Filed

Sept 22, 1930 NE Richardson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 21, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Sept 21, 1930 to Sept 21, 1930

that I last saw her alive on Sept 21, 1930

and that death occurred on the date stated above, at P. m.

The CAUSE OF DEATH \* was as follows:

Acute Alcoholic Poisoning (Accidental)

(Duration)

8 hrs.

yrs. mos. ds.

Contributory Secondary

(Duration)

yrs. mos. ds.

(Signed)

Willard P. Hudson

M. D.

Sept 22, 1930

(Address) Forest Hill Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the

State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chestnut Hill, Md. Sept 23, 1930

20 UNDERTAKER

ADDRESS

H. S. Bailey, Harlington, Md.

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Edema," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County HarfordVillage or City Madonna, Md. (No. \_\_\_\_\_, St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

06773

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 183

(129)

2 FULL NAME Andrew Kinhart

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH

Sept. 23, 1848  
(Month) (Day) (Year)

7 AGE

81 yrs. 8 mos. 9 da. or min. ?  
If LESS than 1 day....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work Merchant(b) General nature of industry business, or establishment in which employed or (employer) Self

9 BIRTHPLACE

(State or country)

Pennsylvania

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER

(State or country)

Not Known

12 MAIDEN NAME OF MOTHER

Ann Heil

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Kinhart(Address) White Hall, Md.

15

Filed

June 2 1920 Thomas R. Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 1, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

May 16 1920, to May 31 1920.  
that I last saw him alive on May 31 1920.and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH was as follows:

Bright DiseaseContributory  
Secondary(Signed) H. F. Bradley M. D.June 2 1920 (Address) Jarrettsville Md.

\*State the Disease Causing Death, or, in deaths from Violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .... yrs. .... mos. .... da. In the State, .... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel, Cem.June 3 1920

20 UNDERTAKER

ADDRESS

E. G. Kurtz & SonJarrettsville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 30 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 3 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Wubler (No. —)

2 FULL NAME Edwin H. Klair

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 ~~STATUS.~~ Married  
~~MARRIED.~~  
~~WIDOWED.~~  
~~OR DIVORCED.~~  
(Write the word)

6 DATE OF BIRTH July 24, 1853  
(Month) (Day) (Year)

7 AGE 77 yrs. 5 mos. 1 ds. or — min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) Retired

9 BIRTHPLACE (State or country) Pa.

10 NAME OF FATHER Hiram Klair

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Ann W. Pearson

13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. W. Harkins

(Address) Wilmington, Md

15 Filed Dec 27 1930 M. W. Kirk -  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 15, 1930 to Dec 25, 1930  
that I last saw him alive on Dec 25, 1930

and that death occurred on the date stated above, at 2 a. m.  
The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis

(Duration) 3 yrs. — mos. — ds.  
Contributory —  
Secondary —

(Duration) — yrs. — mos. — ds.  
(Signed) E. P. Snodgrass M. D.  
19-25-1930 (Address) Wilmington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wilmington, Md DATE OF BURIAL Dec 28, 1930

20 UNDERTAKER H. S. Bailey ADDRESS Wilmington, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architec, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Senile," etc.; "Dropsy," "Debility" ("Congenital," "Senile," etc.); "Convulsions," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u>		09332 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>County Home</u>		Registration Dist. No. <u>182</u>	
2 FULL NAME <u>Henry Graigle</u>		St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)	
6 DATE OF BIRTH <u>About</u> <u>Unknown</u> , 18 <u>60</u> (Month) (Day) (Year)			
7 AGE <u>About 70</u> yrs. _____ mos. _____ ds. or _____ min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>retired</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Farm Labor</u>			
9 BIRTHPLACE (State or country) <u>Md.</u>			
10 NAME OF FATHER <u>Unknown</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>			
12 MAIDEN NAME OF MOTHER <u>Unknown</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. P. J. Fitzpatrick</u> (Address) <u>Bel Air Md</u>			
15 Filed <u>Aug 28</u> 19 <u>30</u> <u>V. E. Chambers</u> <u>Deputy</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Aug 27</u> , 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from 192 <u>8</u> to <u>Aug 27</u> , 192 <u>30</u> that I last saw him alive on <u>Aug 25</u> , 192 <u>30</u> and that death occurred on the date stated above, at <u>11:45 p.m.</u> The CAUSE OF DEATH * was as follows: <u>Myocardial &amp; Chronic nephritis</u> (Duration) _____ yrs. _____ mos. _____ ds.			
Contributory Secondary (Signed) <u>Chas. Richardson</u> M. D. <u>Aug 28</u> 19 <u>30</u> (Address) <u>Baltimore</u>			
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>County Home</u>		DATE OF BURIAL <u>Aug 28</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Dean &amp; Foster</u>		ADDRESS <u>Bel Air Md</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <i>Harford</i>		04387		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <i>Harford</i>		(31)		Registration Dist. No. <i>180</i>	
Village or City <i>Dobbs</i>		(No. _____)		St. _____ Ward _____	
2 FULL NAME <i>Mary Eliz. Kroh</i>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Widowed</i> (Write the word)			
6 DATE OF BIRTH <i>Aug 3</i> , 19 <i>03</i> (Month) (Day) (Year)					
7 AGE <i>76</i> yrs. <i>8</i> mos. <i>3</i> ds. If LESS than 1 day ____ hrs. or ____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <i>Housewife</i> (b) General nature of industry business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <i>Maryland</i>					
PARENTS	10 NAME OF FATHER <i>Henry Baughman</i>				
	11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>				
	12 MAIDEN NAME OF MOTHER <i>Doosy</i>				
	13 BIRTHPLACE OF MOTHER (State or Country) <i>Maryland</i>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <i>Ida V. Pusch</i>					
(Address) <i>2000 W. Enoch St. Belton</i>					
15 Filed <i>April 9</i> 19 <i>30</i> <i>Fred McComas</i> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>Apr 7</i> , 192 <i>0</i> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <i>Jan 6</i> 192 <i>9</i> to <i>Apr 7</i> 192 <i>0</i> , that I last saw him alive on <i>Apr 6</i> 192 <i>0</i> , and that death occurred on the date stated above, at <i>9:15 a.m.</i> The CAUSE OF DEATH * was as follows:					
<i>Chronic Fibroid Tuberculosis</i>					
(Duration) <i>1</i> yrs. ____ mos. ____ ds.					
Contributory Secondary					
(Duration) ____ yrs. ____ mos. ____ ds.					
(Signed) <i>Chas. Port</i> M. D. <i>Edg. Ewood</i>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)					
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.					
Where was disease contracted, if not at place of death? _____					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <i>Mountain Cemetery</i>					DATE OF BURIAL <i>April 10, 1930</i>
20 UNDERTAKER <i>Howard K. McComas</i>					ADDRESS <i>Abingdon, Md.</i>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc.; of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 3 1930

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1 PLACE OF DEATH

County

Harford.

03031

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

Village or City

(No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Rachel J. Kyle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Sept 1, 1860  
(Month) (Day) (Year)

7 AGE

69 yrs. 6 mos. 3 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

House wife

9 BIRTHPLACE

(State or country)

Harford Co., Md.

10 NAME OF FATHER

John H. Hughes.

11 BIRTHPLACE OF FATHER

(State or country)

England.

12 MAIDEN NAME OF MOTHER

Sarah Smith

13 BIRTHPLACE OF MOTHER

(State or country)

Harford Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

See H. Kyle.

(Address)

Whiteford Md.

15

Filed March 5, 1932 H. J. McNabb  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 4, 1932  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1932 to March 4, 1932

that I last saw him alive on March 4, 1932

and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH \* was as follows:

apoplexy

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

W. E. Arthur M. D.

March 4, 1932 (Address) Harford, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Darlington cem. March 7, 1932

20 UNDERTAKER

ADDRESS

Hornbaker &amp; Sons, Beltsville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Labor pneumonia, Bronchopneumonia ("Pneumonia,"*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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BUREAU OF S.

1930  
330  
60



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			09333 STATE OF MARYLAND	
County <u>Harford</u>			CITY OF BALTIMORE	
Village or City <u>Harford</u> (No. _____)			St. _____	Ward _____
2 FULL NAME <u>Elbert P. Larum</u>			Registration Dist. No. <u>185</u>	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u>		
6 DATE OF BIRTH <u>June 19</u> , 18 <u>77</u> (Month) (Day) (Year)				
7 AGE <u>53</u> yrs. <u>1</u> mos. <u>14</u> ds. or min.				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>labor</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Virginia</u>				
PARENTS	10 NAME OF FATHER <u>James Larum</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>			
	12 MAIDEN NAME OF MOTHER <u>Dolly Kritzer</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Virginia</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Mrs. J. P. Larum</u>				
(Address) <u>Harford</u>				
15 Filed <u>Aug. 6</u> 19 <u>30</u> <u>Charles J. Foley</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Aug 3</u> , 19 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>July 24</u> , 19 <u>30</u> to <u>Aug 3</u> , 19 <u>30</u>				
that I last saw him alive on <u>Aug 2</u> , 19 <u>30</u>				
and that death occurred on the date stated above, at <u>10:30</u> p.m.				
The CAUSE OF DEATH * was as follows: <u>Cardiac Decompensation</u>				
(Duration) _____ yrs. _____ mos. _____ ds.				
Contributory Secondary _____				
(Signed) <u>C. J. Foley</u> M. D.				
192 _____ (Address) <u>Harford</u>				
*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)				
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.				
Where was disease contracted, if not at place of death? _____				
Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Alexandria Va.</u>				DATE OF BURIAL <u>Aug. 6</u> 19 <u>30</u>
20 UNDERTAKER <u>Wm. J. Brown</u>				ADDRESS <u>24th</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reveler wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 5 1930

BUREAU



MARGIN RESERVED FOR RECORD  
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

09334 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City Beltin (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John W. Lauterbach

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH August 5, 1911  
(Month) (Day) (Year)

7 AGE 19 yrs. 5 mos. 5 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER William Lauterbach

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna F. Hohlstein

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Anna W. Lauterbach

(Address) Cheriden R. F. D.

15 Filed Aug 12, 1920 NE Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 10, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1920 to 1920

that I last saw him alive on 1920

and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH \* was as follows:

Accidental  
Probably a ruptured blood vessel  
of chest caused by diving fat  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) R. J. Hopkins M. D.

Aug 17, 1920 (Address) Beltin Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baker Cemetery Aug 13, 1920

20 UNDERTAKER

ADDRESS

Henry Tanning Sons Cheriden Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Coronoma, Sorcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL, peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

SEP 8 1907  
BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hampford.

WITHIN CORPORATE LIMITS <sup>(45)</sup>

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 185

Village, or City Laure de Grace (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles Hanson.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH July 20, 1860  
(Month) (Day) (Year)

7 AGE 70 yrs. 4 mos. 27 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Merchant.  
(b) General nature of industry business, or establishment in which employed or (employer) Groceryman.

9 BIRTHPLACE (State or country) Denmark

10 NAME OF FATHER Peter Hanson.

11 BIRTHPLACE OF FATHER (State or country) Denmark.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (State or Country) Denmark.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Charles Hanson

(Address) Laure de Grace

15 Filed Dec 20 1930 by J. J. Magraw Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 17th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct. 15, 1930 to Dec. 17, 1930, that I last saw him alive on Dec. 17, 1930

and that death occurred on the date stated above, at 11:30 P. m.  
The CAUSE OF DEATH \* was as follows:

Carcinoma of Small Intestines  
(Duration) 3 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) J. J. Magraw M. D.  
Dec. 18 1930 (Address) Berryville Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL West Nottingham DATE OF BURIAL Dec. 21, 1930

20 UNDERTAKER Berryville Md. ADDRESS Laure de Grace



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Rencher wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 2 1931

BUR



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hearford

Village or City Castleton (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

2 FULL NAME Ernest Lay

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH about 25 years, 1 \_\_\_\_\_ (Month) (Day) (Year)

7 AGE 25 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION (a) Trade, profession or particular kind of work Farmer (b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pa

10 NAME OF FATHER August Lay

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Thompson

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J J Morris  
(Address) Delta

15 Filed Sep 16 19230 M M Rub Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 15, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192 \_\_\_\_\_ to \_\_\_\_\_ 192 \_\_\_\_\_

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_ 192 \_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Accidental Drowning

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) William B Selfe M. D.

192 \_\_\_\_\_ (Address) Wiley Corner

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Delta DATE OF BURIAL Sept, 1930

20 UNDERTAKER J J Morris ADDRESS Delta Pa



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 8 1930

BUREAU



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Mc Cann's Corner (No. \_\_\_\_\_)

2 FULL NAME James Robert Lee

10481

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

St: \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) —

6 DATE OF BIRTH Aug 6 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. 1 mos. 17 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Harf. co. Md

10 NAME OF FATHER Walter Lee

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Anna McMillan

13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Anna Lee

15 Filed Sept. 26 1930 V. E. Chambers Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 25 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 6 1930 to Sept 23 1930, that I last saw him alive on Sept 23 1930, and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH \* was as follows:

Malnutrition Complicated by Embolus

(Duration) \_\_\_\_\_ yrs. 1 mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Willard P. Hudson M. D.  
Sept 26 1930 (Address) Forest Hill Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Clark's Chapel DATE OF BURIAL Sept 26 1930

20 UNDERTAKER Walter Lee, father ADDRESS Street.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (c) Stevedore, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Teacher," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Norman, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Scarlet pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucositis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intermittent) affection need not be stated unless important. Example: *Mucositis (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 7 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Hearford</u>			10482 (88) WITHIN CORPORATE LIMITS OF			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Harrods Grace</u> (No. _____)			St. _____ Ward _____			Registration Dist. No. <u>185</u>		
2 FULL NAME <u>Lucy C. Lee</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)					
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Female</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>widowed</u> (Write the word)						
6 DATE OF BIRTH <u>Sept. 21 - 1879</u> (Month) (Day) (Year)		7 AGE <u>57</u> yrs. <u>11</u> mos. <u>14</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____								
9 BIRTHPLACE (State or country) <u>Maryland</u>								
PARENTS								
10 NAME OF FATHER <u>John Beiggold</u>								
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>								
12 MAIDEN NAME OF MOTHER <u>Susie Parson</u>								
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. H. A. Swan</u> (Address) <u>New York, N.Y.</u>								
15 Filed <u>Sept 7 1930</u> <u>Chas. J. Foley, Md.</u> Registrar								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>Sept. 5, 1930</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 5 1930</u> to <u>Sept 5 1930</u> , that I last saw him alive on <u>Sept 5 1930</u> , and that death occurred on the date stated above, at <u>7 A.</u> m. The CAUSE OF DEATH * was as follows: <u>Acute Peritonitis</u> <u>Acute Myocarditis</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>Cardiac Failure</u> Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Martin R. Foley "Coroner"</u> M. D. <u>Sept 5 1930</u> (Address) <u>Harrods Grace Md</u>								
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____								
19 PLACE OF BURIAL OR REMOVAL <u>Union Cem. Sub Creek</u>						DATE OF BURIAL <u>Sept. 7, 1930</u>		
20 UNDERTAKER <u>Pennington &amp; Son</u>						ADDRESS <u>H. de Grace, Md.</u>		
If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.								



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Dec. 28, 1844, 1 (Month) (Day) (Year)

7 AGE 85 yrs. 11 mos. 7 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION (a) Trade, profession or particular kind of work House Wife (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Henry Dallmeyer

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Harry Luman

(Address) 204 Shady North St.

15 Filed Dec. 5, 1930, D. E. Chambers, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 5th, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 28th, 1930, Dec 4th, 1930,

that I last saw her alive on Dec 4th, 1930,

and that death occurred on the date stated above, at 1:25 p.m.

The CAUSE OF DEATH was as follows: Chronic Valvular heart disease

Contributory Secondary (Duration) / yrs. mos. ds.

(Signed) J. H. M. D. 1930 (Address) Baldwin

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Weston Cemetery Dec 8, 1930

20 UNDERTAKER 2303 ADDRESS Ave Sea Weber & Son Edmonson



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 3 1931

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL; or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence, and the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hager

Village or City Edgewood (No. ....)

2 FULL NAME Aurelia Coraine Litchfield

01736 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH Sept-Oct-22, 1929  
(Month) (Day) (Year)

7 AGE 3 yrs. 12 mos. 12 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Harmon Litchfield

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sadie Harmon

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harmon Litchfield  
(Address) Edgewood Md

15 Filed Feb 5 1930 Fred Marshall  
local Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_, 192 \_\_\_\_ to \_\_\_\_\_, 192 \_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 192 \_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Unknown - apparently in good health - probably choked on its milk bottle. (Duration) Aug 02 yrs. 2 mos. 12 ds.

Contributory  
Secondary

(Signed) Chas R. Roth M. D.  
Feb 4 1930 (Address) Edgewood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Trinity Lutheran Cemetery Feb 6, 1930

20 UNDERTAKER ADDRESS  
Howard K. McComas Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly, and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 5 1939  
BUREAU V. 2



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Berryman (No. \_\_\_\_\_)

2 FULL NAME F. William Lieske

(74-a)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 181

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH Feb 22 1942  
(Month) (Day) (Year)

7 AGE 88 yrs. 2 mos. 25 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work At home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Fred Lieske

(Address) Abandon Rd

15 Filed May 19 19230 H. Michael  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 17 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 1927 to May 17 19230

that I last saw him alive on April 17 19250

and that death occurred on the date stated above, at 1:58 p.m.

The CAUSE OF DEATH \* was as follows:

Central Hemorrhage  
followed by pneumonia

Contributory Secondary Anthraxis  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Dr. Otis M. D.  
May 18 19230 (Address) Berryman

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Lutheran Cemetery DATE OF BURIAL May 19 19230

20 UNDERTAKER Henry Farrington ADDRESS Abandon Rd



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Puglist, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up, on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Trophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUN 4 1930  
BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford6514 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 184Village or City Washington (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Harriet Irene Little

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>WIDOWED</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH Jan. 15, 1930  
(Month) (Day) (Year)7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds. or \_\_\_\_\_ min.8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Harford Co. Md10 NAME OF FATHER Oscar N. Little11 BIRTHPLACE OF FATHER (State or country) Harford Co. Md12 MAIDEN NAME OF MOTHER Carrie Helen Cooper13 BIRTHPLACE OF MOTHER (State or Country) York Co. Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oscar N. Little(Address) Washington, Md15 Filed Jan 19 - 1930 H. J. McRabb  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 18, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Jan. 15, 1930 to Jan. 15, 1930, that I last saw her alive on Jan. 15, 1930,and that death occurred on the date stated above, at 7:30 a.m.  
The CAUSE OF DEATH \* was as follows:Did not see child from date of birth but from symptoms given by mother think it died of Pneumonia  
Broncho-pneumonia, acute  
Contributory Secondary \_\_\_\_\_(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) H. E. Arthur M. D.  
Jan. 18, 1930 (Address) Cardiff, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Talbot County Jan 20, 193020 UNDERTAKER ADDRESS  
Russell Dallas



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired, 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchiopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchiopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1930

BUREAU



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## 1 PLACE OF DEATH

County Harford

WITHIN CORPORATE LIMITS OF

13856 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Harford (No. 1)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Catherine Enson Litzinger

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH Oct. 10, 1924  
(Month) (Day) (Year)7 AGE 6 yrs. 1 mos. 5 ds. or 5 min. If LESS than 1 day \_\_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER John E. Litzinger11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Rachael V. Pierce13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. John E. Litzinger(Address) Chesapeake road15 Filed Nov. 16, 1930 Chesapeake Talbot MD.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 15, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov 15, 1930 to Nov 15, 1930that I last saw him alive on Nov 15, 1930and that death occurred on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH \* was as follows:

Gun shot wound of upper part of right thigh  
Accidental shot(Duration) 5 hrs. yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_Contributory Shock & hemorrhage  
Secondary(Duration) 15 hrs. yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_(Signed) Martin P. Foley, M.D. M.D.Nov 15, 1930 (Address) Chesapeake

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Assunta Cemetery Nov. 17, 1930

20 UNDERTAKER

ADDRESS

Henry Tanning Chesapeake



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1930



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1 PLACE OF DEATH

County

WITHIN CORPORATE LIMITS OF

01737

(179)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Feb 7, 1930

Chas. J. Foley, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
Jan 15, 1929 to Feb 6, 1930.

that I last saw him alive on Feb 6, 1930.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Close contact with hot stove, clothing  
burned off knee joint,  
due to Burn of third degree  
caught fire.

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

Feb 7, 1930

(Address)

Fam &amp; Gen Med

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

Bel Air, Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Henderson Hill

Feb 6, 1930

20 UNDERTAKER

ADDRESS

Dean &amp; Fort

Bel Air, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Degeneration," "Senility," etc.; "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. If the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAR 6 1920

BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Level (No. —)

2 FULL NAME Hamville Loggins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE wh. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Oct. 17 1929  
(Month) (Day) (Year)

7 AGE No. yrs. 11 mos. 14 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

OCCUPATION

(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) None

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER H. E. Loggins

11 BIRTHPLACE OF FATHER (State or country) M.C.

12 MAIDEN NAME OF MOTHER Minnie Lorne

13 BIRTHPLACE OF MOTHER (State or country) M.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. E. Loggins

(Address) Harville Grace

15 Filed Oct 1 1930 Bethel B. Knight  
Registrar

12501

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. — Ward — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 1 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 20 1930 to Oct 1 1930,

that I last saw him alive on Sept 29 1930.

and that death occurred on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH \* was as follows:

Broncho-Pneumonia  
Complicating Pericarditis  
(Duration) \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Willard B. Hudson M. D.  
Oct 1 1930 (Address) Forest Hill, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds. In the State \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Pine Creek M.C. DATE OF BURIAL Oct. 3, 1930

20 UNDERTAKER H. S. Bailey ADDRESS Harville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Soleman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Teacher," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Scarlet pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling brick—accident; Beecher wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate be permanently filed.

NOV 5 1900  
BUREAU



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

Village or City

Palletta (No. \_\_\_\_\_)

2 FULL NAME

John FERRIS LOVER

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May 2, 1844 (Month) (Day) (Year)

7 AGE

86 yrs. 7 mos. 2 da. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Carpenter

9 BIRTHPLACE (State or country)

Harford Co Md

10 NAME OF FATHER

Joseph Lover

11 BIRTHPLACE OF FATHER

(State or country) Germany

12 MAIDEN NAME OF MOTHER

Mary Whitson

13 BIRTHPLACE OF MOTHER

(State or Country) Harford Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Theresa Denton

(Address)

1 Franklin St. Md

15

Filed Dec. 6, 1920 J. E. Chambers

Registrar

15072

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

1832

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 4, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 1, 1920, to Dec. 4, 1920, that I last saw him alive on Dec. 1, 1920,

and that death occurred on the date stated above, at 3 P. m. The CAUSE OF DEATH \*, was as follows:

Hemiplegia

(Duration) yrs. 6 mos. 7 da. Contributory Secondary Arterio Sclerosis

(Signed) M. D. 12/5/20 (Address) Palletta Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Friends Cemetery Dec. 6, 1920

20 UNDERTAKER

HARRIS &amp; GROSS Benson

DATE OF BURIAL



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931

BUREAU V. S.



MARGIN RESERVED FOR BIRTHING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

1 PLACE OF DEATH  
County Harford

Village or City Joppa (No. \_\_\_\_\_)

2 FULL NAME Elizabeth Susanna Lomeyer

04800 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Mar 18 1879  
(Month) (Day) (Year)

7 AGE 51 yrs. 1 mos. 10 ds. or min.?  
IF LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles Be Venzke

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Susan Botal

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William H Lomeyer

(Address) Joppa Md

15 Filed Apr 30 1920 Fred Worlock Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 28 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 1 1918 to April 28 1920

that I last saw him alive on April 28 1920

and that death occurred on the date stated above, at 4:30 AM

The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis  
Hemiplegia  
Chronic Bronchitis  
Myocardial Degeneration  
(Duration) yrs. mos. ds.

Contributory Cardiac Failure  
Secondary

(Signed) Charles J. Foley M.D.  
April 30 1920 (Address) Harford County

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Trinity Luthern Cemetery May 1 1920

20 UNDERTAKER ADDRESS

Howard K. McComas, Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH, the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Typhoid* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory," (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





MARGIN RESERVED FOR EMBELLISHING  
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Lapidum (No. \_\_\_\_\_)

2 FULL NAME William S. Loomore

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH August 25<sup>th</sup>, 1913  
(Month) (Day) (Year)

7 AGE 16 yrs. 10 mos. 12 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Blacksburg West Va

10 NAME OF FATHER John Loomore

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Hannah Reese

13 BIRTHPLACE OF MOTHER (State or Country) Wales

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry C. Werner

(Address) 43 N. Kresson St. Baltimore

15 Filed July 6 1930 Chas. J. Foley MD  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 5<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192\_\_\_\_ to \_\_\_\_\_ 192\_\_\_\_,

that I last saw him alive on \_\_\_\_\_ 192\_\_\_\_,

and that death occurred on the date stated above, at 5<sup>20</sup> P. M.

The CAUSE OF DEATH \* was as follows:  
From Drowning (Accidental)

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Martin P. Foley Coroner M. D.

July 6<sup>th</sup> 1930 (Address) Wheatfield Grace Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery  
Baltimore Md

DATE OF BURIAL

July 9, 1930

20 UNDERTAKER

Wm. Cook

ADDRESS

Baltimore Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicemia*, "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

County Harford

WITHIN CORPORATE LIMITS OF

12502

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Harford (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary R. Love

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED - married  
(Write the word)6 DATE OF BIRTH December 23, 1874  
(Month) (Day) (Year)7 AGE 55 yrs. 10 mos. 5 ds. or 5 min. 7  
If LESS than 1 day \_\_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work housework  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Pennsylvania10 NAME OF FATHER John R. Wood11 BIRTHPLACE OF FATHER Pennsylvania  
(State or country)12 MAIDEN NAME OF MOTHER Mary Beattie13 BIRTHPLACE OF MOTHER Pennsylvania  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rose Love(Address) Harford Grace Md15 Filed Oct 31, 1920 Charles J. Tobey Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 29, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 1st, 1920 to Oct 29th, 1920, that I last saw him alive on Oct 28th, 1920and that death occurred on the date stated above, at 12:30 p.m.  
The CAUSE OF DEATH \* was as follows:Paralysis - Cerebral  
Hæmorrhage (Left Hem)  
(Duration) 2 yrs. 2 mos. 2 ds.Contributory Arteriosclerosis  
Secondary(Signed) J. L. Hopson M. D.  
Oct 31, 1920 (Address) Harford Grace Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Union Free Pa DATE OF BURIAL Nov. 1, 192020 UNDERTAKER Penningtons ADDRESS Harford Grace Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

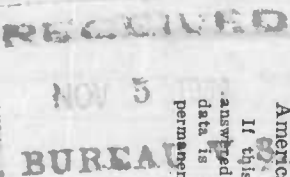
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

STATE OF MARYLAND  
CERTIFICATE OF DEATH

0515

Registration Dist. No. 180

Village or City

Joppa

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Eless Lowery

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Widow

6 DATE OF BIRTH

Oct

8

1846

(Month)

(Day)

(Year)

7 AGE

88

yrs.

3

mos.

11

ds.

If LESS than

1 day \_\_\_\_\_ hrs.

or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Cennie M Shirart

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Lowery

(Address)

Joppa, Md

15

Filed

Jan 19

1920

by Harry Anderson

Registrar

16 DATE OF DEATH

Jan 19

1920

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1920

to

Jan 19

1920

that I last saw him alive on

Dec 28

1920

and that death occurred on the date stated above, at 9 a m.

The CAUSE OF DEATH \* was as follows:

Myocarditis

(Duration)

yrs. 6

mos. \_\_\_\_\_ ds. \_\_\_\_\_

Contributory  
Secondary

(Duration)

yrs. \_\_\_\_\_

mos. \_\_\_\_\_ ds. \_\_\_\_\_

(Signed)

Jan 19 1920

(Address)

Edge wood

M. D.

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

In the

State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Cemetery

Jan 21, 1920

20 UNDERTAKER

David Davidson

ADDRESS

Upper Falls



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *Name.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 5 1930  
BUREAU V. S.



Report made to Department of Commerce Bureau of Census, Wash. D.C.

## PLACE OF DEATH

15073

STATE OF MARYLAND  
CERTIFICATE OF DEATHCounty HarfordRegistration Dist. No. 181Village or City Aberdeen Proving Ground, (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Margaret Edith Ludlam

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <b>Female</b>	4 COLOR OR RACE <b>White</b>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <b>Married</b> (Write the word)
------------------------	---------------------------------	---

6 DATE OF BIRTH  
September 24, 1904  
(Month) (Day) (Year)7 AGE  
26 yrs. 4 mos. 0 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) Housewife9 BIRTHPLACE  
(State or country) Newport, R.I.10 NAME OF FATHER J. George Featherstone11 BIRTHPLACE OF FATHER  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Gertrude White13 BIRTHPLACE OF MOTHER  
(State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Douglas G. Ludlam(Address) Aberdeen Proving Ground, Md.15 Filed Dec. 24 1930 O. C. Mitchell  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
December 24th, 1930December (Month) 24 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
December 14 1930 to December 24 1930that I last saw her alive on December 24, 1930,and that death occurred on the date stated above, at 9.00 A.m.

The CAUSE OF DEATH \* was as follows:

Scarlet Fever(Duration) 0 yrs. 0 mos. 10 ds.Contributory  
SecondaryD.C. Absher (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) D.C. Absher, Major, Med. Corps M. D.Dec. 24 1930 (Address) Aberdeen Proving Ground Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 6 mos. 0 ds. In the State 0 yrs. 6 mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence Newport, R.I.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Philadelphia, Pa.Dec. 27, 1930

20 UNDERTAKER

ADDRESS

R. W. MitchellHayre de Grace Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR  
WRITING, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealtor," etc., without more precise specification as *Day laborer, Farm laborer, Loberer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered, as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Corioma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hnition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 6 1931

BUREAU



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Harford

10483 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City Tzel Air (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. William A. Isabel M. Lyon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH May 1<sup>st</sup>, 1861  
(Month) (Day) (Year)

7 AGE 69 yrs. 4 mos. 6 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Christopher Scherer

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER Margaret Fisher

13 BIRTHPLACE OF MOTHER (State or Country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Lyons

(Address) Phila Pa

15 Filed Sept 6<sup>th</sup> 1930 H. E. Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 6<sup>th</sup>, 1930  
(Month) (Day) (Year)

I HEREBY CERTIFY, that deceased was brought to my office at about 6 P.M. this date. She died a few minutes after I first saw her.

The CAUSE OF DEATH \* was as follows:

Broken neck  
(automobile accident)  
Less than 1/2 hour  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) A. F. Van Tibber M. D.  
Sept 6<sup>th</sup> 1930 (Address) Tzel Air, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Green Mount Cem. Balto. DATE OF BURIAL Sept 9, 1930

20 UNDERTAKER Henry W. Meason ADDRESS 805 N. Calvert

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

Balto.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia",

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 7 1930

BUREAU



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Harford*

0517

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *182*Village or City *Beltair* (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Michael Maddox*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

*Widowed*

6 DATE OF BIRTH

*About 65* 1865  
(Month) (Day) (Year)

7 AGE

*65* yrs. *unknown* mos. ds. or min.?  
If LESS than 1 day... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Naturalist*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Ireland*

10 NAME OF FATHER

*unknown*

11 BIRTHPLACE OF FATHER

(State or country)

*unknown*

12 MAIDEN NAME OF MOTHER

*unknown*

13 BIRTHPLACE OF MOTHER

(State or country)

*unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

*Fitzpatrick*  
(Informant) *Harford Co. Blue House*  
(Address) *Beltair, Md.*

15

Filed *Jan 27 1930* *M. E. Richardson*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Jan 25*, 19*30*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *Jan 25*, 19*30* to *Jan 25*, 19*30*that I last saw him alive on *Jan 24*, 19*30*and that death occurred on the date stated above, at *9314* n.

The CAUSE OF DEATH \* was as follows:

*Apoplexy*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) *Chas. Richardson* M. D.*Jan 27 1930* (Address) *Beltair, Md.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Ignace Catholic Church* *Jan 28, 1930*

20 UNDERTAKER

ADDRESS

*Koruberg & Gross* *Beltair, Md.*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc., Woman at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Syphilis, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 4 1930  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City (Rocks) Rocks, Md. (No. 740)2 FULL NAME Otho Elmore MagnessSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 183

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH September 12, 1861  
(Month) (Day) (Year)7 AGE 69 yrs. 1 mos. 12 ds. If LESS than 1 day, hrs. or min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER James McFadden Magness11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Susan De Moss13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Magness  
(Address) Sharon Md.15 Filed Oct 25 1930 Thomas R. Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 24, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Oct 1, 1930 to Oct 22, 1930that I last saw him alive on Oct 22, 1930and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH \* was as follows:

Haemorrhage of Brain(Duration) 21 yrs. mos. ds.Contributory  
Secondary(Duration) 21 yrs. mos. ds.(Signed) Charles W. Brown M. D.Oct 25 1930 (Address) Sharon Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 21 yrs. 1 mos. 12 ds. In the State 21 yrs. 1 mos. 12 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Carmel Cem Emmorton DATE OF BURIAL Oct 27, 193020 UNDERTAKER C. M. O. Deroe ADDRESS Pylesville



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

RECEIVED  
NOV 6 1924



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Edgewood, Md. (No. \_\_\_\_\_)03035 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180

St. \_\_\_\_\_ Ward) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lawrence Malone

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH  
February 12, 1904  
(Month) (Day) (Year)7 AGE  
26 yrs. 0 mos. 20 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Soldier  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE  
(State or country) Indiana10 NAME OF FATHER  
Unknown11 BIRTHPLACE OF FATHER  
(State or country) Indiana12 MAIDEN NAME OF MOTHER  
Unknown13 BIRTHPLACE OF MOTHER  
(State or Country) Indiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Records, U. S. Army.(Address) Fort Hoyle, Md.15 Filed March 5 1930 Fred Moorlock Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
March 4, 1930.17 I HEREBY CERTIFY, That I attended the deceased from  
March (Month) 4 (Day) 1930 (Year)  
February 23, 1930 to March 4, 1930,that I last saw him alive on March 4, 1930,  
and that death occurred on the date stated above, at 10:30 A m.

The CAUSE OF DEATH \* was as follows:

Meningitis, type undetermined.Contributory  
Secondary(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Walter L. Richards M. D.  
WALTER L. RICHARDS, Major, M.C.  
March 4, 1930 (Address) Edgewood Arsenal, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

DANA IndUNKNOWN, 19

20 UNDERTAKER

ADDRESS

HOWARD McCOMASAbingdon, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*, (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 1 1910

BUREAU



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1 PLACE OF DEATH

County Harford

08087

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 183Village or City Jarrettsville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Markley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widower</u> (Write the word)
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6 DATE OF BIRTH  
June 15, 1858  
(Month) (Day) (Year)7 AGE  
72 yrs. 1 mos. 2 ds. or 1 day 1 hrs. 1 min.  
IF LESS than8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE  
(State or country) Balto. Co. Md.10 NAME OF FATHER  
Frederick Markley11 BIRTHPLACE OF FATHER  
(State or country) Germany12 MAIDEN NAME OF MOTHER  
Not Known13 BIRTHPLACE OF MOTHER  
(State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Markley(Address) Rocks Md.15 Filed July 19, 1930 Thomas R. Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
July 16, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
July 4, 1930 to July 15, 1930  
that I last saw him alive on July 15, 1930and that death occurred on the date stated above, at 11 a.m.  
The CAUSE OF DEATH \* was as follows:Thrombosis & Gangrene of  
Left leg. Below the knee  
with heart fibrillation  
(Duration) 1 yrs. 1 mos. 10 ds.Contributory  
Secondary Thrombosis(Duration) 1 yrs. 1 mos. 10 ds.(Signed) H. F. Bradley M. D.July 20, 1930 (Address) Jarrettsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 10 ds. In the State 1 yrs. 1 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL  
Jarrettsville, Cem.DATE OF BURIAL  
July 20, 1930

20 UNDERTAKER

ADDRESS

E. G. Kurtz & Son Jarrettsville,



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u> Village or City <u>near Forest Hill</u> (No. _____) St. _____ Ward _____			STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>182</u>		
2 FULL NAME <u>James T Martin</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>			
6 DATE OF BIRTH <u>Dec 3, 1894</u> (Month) (Day) (Year)					
7 AGE <u>36</u> yrs. <u>2</u> mos. <u>10</u> ds. If LESS than 1 day ____ hrs. or ____ min.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>md</u>					
PARENTS	10 NAME OF FATHER <u>Frank Martin</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>md</u>				
	12 MAIDEN NAME OF MOTHER <u>Annie Lagon</u>				
	13 BIRTHPLACE OF MOTHER (State or Country) <u>md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Frank Martin</u> (Address) <u>Forest Hill</u>					
15 Filed <u>Feb 14</u> 19 <u>30</u> <u>N.E. Richardson</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Feb 13</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb 11<sup>th</sup></u> 19 <u>30</u> to <u>Feb 13</u> , 19 <u>30</u> , that I last saw him alive on <u>Feb 13</u> , 19 <u>30</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Chronic Myocardial Disease</u>					
Contributory (Duration) <u>2</u> yrs. ____ mos. ____ ds. Secondary <u>Bronchial Asthma + Congestion of right lung</u> <u>Asthma</u> (Duration) <u>2</u> yrs. ____ mos. ____ ds.					
(Signed) <u>Willard P. Hudson</u> M. D. <u>Feb 14</u> 19 <u>30</u> (Address) <u>Forest Hill, Md</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>St Ignatius</u> DATE OF BURIAL <u>Feb 15, 1930</u>					
20 UNDERTAKER <u>Dean &amp; Foster Bel An Md</u> ADDRESS _____					

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over, thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be supplied before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

04389

2

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.; Ward)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Contributory  
Secondary

(Signed)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Francis Cemetery

April 7, 1930

20 UNDERTAKER

ADDRESS

Howard K. McComas,

Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—(*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired) (e gys.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *metem-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicemia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 3 1930  
BUREAU V. B.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

08088

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City

New Bel Air Md

St.: Ward:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John E Mathews

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Unknown

6 DATE OF BIRTH

Unknown

7 AGE

about 80 yrs. mos. ds. or min.?

If LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

None

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Dr. Fitzpatrick  
Bel Air Md  
July 22 1930  
J. E. Richardson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 21, 1930

17 I HEREBY CERTIFY, That I attended the deceased from 1928 to July 21, 1930

that I last saw him alive on July 21, 1930

and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH \* was as follows:

Myocardial infarction

Contributory Secondary

(Signed) Chas. Richardson M. D.

July 22 1930 (Address) Bel Air Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

County Home July 22, 1930

20 UNDERTAKER

ADDRESS

Dean's Lot Bel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

RECEIVED  
AUG 5 1930

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Hanford

Village or City Bel Air (No. \_\_\_\_\_)

<sup>2</sup> FULL NAME Emma K Mc Abbe

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Oct 29 1862  
(Month) (Day) (Year)

7 AGE 68 yrs. 9 mos. 27 ds. IF LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Teacher  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Hanson Cole

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Susan Proctor

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Raymond McAbbe

(Address) Bel Air

15 Filed Aug 3 1930 E. Richardson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 2nd 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1920 to Aug 2nd 1930

that I last saw him alive on Aug 1st 1930

and that death occurred on the date stated above, at 7 A. m.

The CAUSE OF DEATH \* was as follows:

Myocarditis + Chronic Nephritis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) Chas. Richardson M.D.  
Aug 2nd 1930 (Address) Bel Air md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Carmel Aug 4, 1930

20 UNDERTAKER ADDRESS

Dean G. Foster Bel Air



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford. WITHIN CORPORATE LIMITS <sup>95</sup>STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Lane de Saer Md. Howard (No. 1) St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Ellwood McClure

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH May 28, 1877  
(Month) (Day) (Year)7 AGE 52 yrs. 11 mos. 28 ds. or 1 day 28 hrs. min.?  
If LESS than 1 day8 OCCUPATION  
(a) Trade, profession or particular kind of work Conductor  
(b) General nature of industry, business, or establishment in which employed or (employer) P. R. R. Co.9 BIRTHPLACE (State or country) Laurens Co. Pa.10 NAME OF FATHER Thomas McClure11 BIRTHPLACE OF FATHER (State or country) Laurens Co. Pa.12 MAIDEN NAME OF MOTHER Margaret Sampson13 BIRTHPLACE OF MOTHER (State or Country) Laurens Co. Pa.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William McClure(Address) 115 Filed May 26, 1930 Chas. J. Foley, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 26, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept. 3, 1927 to May 26, 1930, that I last saw him alive on May 26, 1930, and that death occurred on the date stated above, at 6:09 a.m.

The CAUSE OF DEATH \* was as follows:

1. Myocardial infarction  
2. Atherosclerosis  
3. Mitral Regurgitation  
(Duration) 6 yrs. 6 mos. 0 ds.Contributory Pulmonary Edema Cardiac Failure  
Secondary(Signed) Chas. J. Foley M. D. 5/26/1930 (Address) Harford

\*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 7 yrs. 7 mos. 7 ds. In the State 7 yrs. 7 mos. 7 ds.Where was disease contracted, if not at place of death? ?Former or usual residence ?19 PLACE OF BURIAL OR REMOVAL Oxford Cemetery DATE OF BURIAL 1920 UNDERTAKER C. P. Rogers ADDRESS ?



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architec, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 5 1930  
BUREAU V



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

12503

(90)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE.

MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work

(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF

FATHER

PARENTS

11 BIRTHPLACE

OF FATHER

(State or country)

12 MAIDEN NAME

OF MOTHER

13 BIRTHPLACE

OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Oct. 14

1923

Fred A. Barlow

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 13

1923

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1926

192

to Oct 13

1923

that I last saw him alive on

Oct 13

1923

and that death occurred on the date stated above, at 11:20 P. M.

The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis

(Duration)

4

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Oct 13 1923

(Address)

Edgewood

M. D.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,  
if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Angel Hill

Oct 15, 1923

20 UNDERTAKER

ADDRESS

Howard K. Melton

Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired, 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

NOV 4 1930

BUREAU

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus)* may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			Registration Dist. No. <u>185</u>	
Village or City <u>Hdelsrace</u> (No. ....)			St. ....	Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Gertrude M Daniels</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female colored</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>widow</u> (Write the word)		
6 DATE OF BIRTH <u>October 20</u> , 1877 (Month) (Day) (Year)				
7 AGE <u>52</u> yrs. <u>9</u> mos. <u>-</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>housework</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>-</u>				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
PARENTS	10 NAME OF FATHER <u>Shirley Waters</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
	12 MAIDEN NAME OF MOTHER <u>Mary Dallam</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Edw. Giddings</u> (Address) <u>Hdelsrace rd.</u>				
15 Filed <u>July 22</u> 19 <u>30</u> <u>Charles J. Foley</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>July 20</u> , 19 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>July 10</u> , 19 <u>30</u> to <u>July 20</u> , 19 <u>30</u> , that I last saw him alive on <u>July 19</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>6:20 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Arterio Sclerosis</u> <u>Paralysis</u> (Duration) .... yrs. .... mos. .... ds. Contributory <u>Cardiac Failure</u> Secondary (Duration) .... yrs. .... mos. .... ds. (Signed) <u>Charles J. Foley</u> M. D. <u>7/22</u> 19 <u>30</u> (Address) <u>Phoenix and 2nd</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds. Where was disease contracted, if not at place of death? Former or usual residence .....				
19 PLACE OF BURIAL OR REMOVAL <u>Green Spring lawn</u>				DATE OF BURIAL <u>July 23</u> 19 <u>30</u>
20 UNDERTAKER <u>Levinson</u>				ADDRESS <u>Hdelsrace</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Coremia, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masks; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Masks (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR RECORDING  
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH			03032 STATE OF MARYLAND	
County <u>Harford</u>			CERTIFICATE OF DEATH	
Village or City <u>Perryman</u> No. _____			St. _____	Ward _____
2 FULL NAME <u>Catherine T. McDonald</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widow</u>		
6 DATE OF BIRTH <u>May 15, 1882</u> (Month) (Day) (Year)				
7 AGE <u>77</u> yrs. <u>10</u> mos. <u>4</u> ds. or min. If LESS than 1 day, hrs.				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Ireland</u>				
PARENTS	10 NAME OF FATHER <u>Daniel O'Leary</u>			
	11 BIRTHPLACE OF FATHER <u>Ireland</u> (State or country)			
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>			
	13 BIRTHPLACE OF MOTHER <u>Unknown</u> (State or Country)			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Mr. J. J. McDonald</u>				
(Address) <u>2400 Race Rd.</u>				
15 Filed <u>March 20 1930</u>	16 REGISTRAR <u>J. J. McDonald</u>			
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>March 20, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 6, 1929</u> to <u>March 20, 1930</u> , that I last saw her alive on <u>March 16, 1930</u> , and that death occurred on the date stated above, at <u>6-20 a.m.</u>				
The CAUSE OF DEATH * was as follows: <u>Myocarditis</u>				
(Duration) _____ yrs. _____ mos. _____ ds.				
Contributory Secondary _____				
(Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>J. J. Stiles</u> M. D.				
3120 1930 (Address) <u>Perryman Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)				
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.				
Where was disease contracted, if not at place of death? _____				
Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>West Green Cemetery</u>				DATE OF BURIAL <u>March 22, 1930</u>
20 UNDERTAKER <u>Perryman Md.</u>				ADDRESS <u>2400 Race Rd.</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicemia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a question answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930  
BUREAU V. C.



WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County HarfordVillage or City Harrods Creek (No. \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Katherine Mc Fadden

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, <u>yes</u> , MARRIED, <u>single</u> , WIDOWED, OR DIVORCED (Write the word)
------------------------	---------------------------------	---

6 DATE OF BIRTH <u>Oct 7</u> , 1929 (Month) (Day) (Year)
--

7 AGE <u>9 months</u> yrs. <u>8</u> mos. <u>24</u> ds. or min.?	If LESS than 1 day ____ hrs. or min.?
---	---

8 OCCUPATION a) Trade, profession or particular kind of work b) General nature of industry, business, or establishment in which employed (or employer)	<u>None</u>
--	-------------

9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Lewis Mc Fadden11 BIRTHPLACE OF FATHER (State or country) Penn a.12 MAIDEN NAME OF MOTHER Billy Boyd13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis McFadden(Address) Clinton Del. RFD15 Filed July 1, 1930 Chas. J. Foley, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 1st, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from June 29, 1920, to July 1, 1920,  
that I last saw her alive on June 30, 1920.and that death occurred on the date stated above, at 4:20 P. m.  
The CAUSE OF DEATH \* was as follows:Cardiac Decomposition  
Pneumonia  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory  
Secondary(Signed) [Signature] M. D.  
7-1, 1920 (Address) Ham. L. Ave. Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Tempsville Cemetery July 3, 1930

20 UNDERTAKER ADDRESS

Henry Jamieson, Aberdeen Md.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer. Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Melas (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Joppa (No. \_\_\_\_\_)

2 FULL NAME Joseph Augustus McQuigan

0516

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Aug 22, 1868  
(Month) (Day) (Year)

7 AGE 61 yrs. 4 mos. 12 ds. If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Carpenter  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John S. McQuigan

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Morrisson

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Joe McQuigan

(Address) Joppa

15 Filed Jan. 4, 1930 Fred A. Borlak Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 3, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 7 a.m. 192

and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH \* was as follows:

Pericardial hemorrhage

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Charles R. Bode M. D.

Jan 3, 1930 (Address) Edgewood Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Stephens Cemetery, Jan. 6, 1930

20 UNDERTAKER

ADDRESS

Howard E. McComas Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford County

13857

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 180

Village or City Churchville (No. 129)

St.: \_\_\_\_\_ Ward: \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Marian McGonigall

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH March 28, 1847  
(Month) (Day) (Year)

7 AGE 83 yrs. 8 mos. 5 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Daniel McGonigall

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Awarilla Smith

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. H. Scarborough  
(Address) Churchville Md.

15 Filed Nov 5 1930 Fred Charlak Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 3rd, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from 1925 to Nov 2nd, 1923

that I last saw him alive on Nov 2nd, 1923

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Acute Nephritis  
+ Myocarditis  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Chas. Richards M.D.  
Nov: 4 1923 (Address) Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Churchville Protestant Cemetery DATE OF BURIAL Nov 5, 1930

20 UNDERTAKER Howard K. McLean ADDRESS Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH		WITHIN CORPORATE LIMITS 03033		STATE OF MARYLAND	
County <u>Harford</u>		(90)		CERTIFICATE OF DEATH	
Village or City <u>Old Grace</u> (No. <u>Hospital</u> )		St. <u></u> Ward <u></u>		Registration Dist. No. <u>185</u>	
2 FULL NAME <u>Thomas McEach</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Unknown</u>			
6 DATE OF BIRTH <u>Unknown</u>		(Month) (Day) (Year)			
7 AGE <u>abt. 67</u> yrs. - mos. - ds.		IF LESS than 1 day hrs. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Labour</u> (b) General nature of industry business, or establishment in which employed or (employer) <u></u>					
9 BIRTHPLACE (State or country) <u>Unknown</u>					
PARENTS	10 NAME OF FATHER <u>Unknown</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>				
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Old Grace Hospital</u> (Address) <u>Old Grace, Md.</u>					
15 Filed <u>Apr. 3 1923</u> <u>Chas. J. Foley, M.D.</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Mar 27 1920</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb 7 1920</u> to <u>Mar 27 1920</u> that I last saw him alive on <u>Mar 27 1920</u> and that death occurred on the date stated above, at <u>3 P. m.</u> The CAUSE OF DEATH * was as follows: <u>Chronic Bronchitis</u> <u>Senility - Cardiac Decompensation</u> (Duration) yrs. mos. ds.					
Contributory Secondary (Duration) yrs. mos. ds.					
(Signed) <u>[Signature]</u> M. D. <u>7/2 1920</u> (Address) <u>Old Grace Md</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Mt. Pinemontary</u>				DATE OF BURIAL <u>April 3, 1920</u>	
20 UNDERTAKER <u>Pennington &amp; Son</u>				ADDRESS <u>H. De. Grace, Md</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 9 1918  
BUREAU



WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Hanford

12504 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

Village or City Cardiff (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME David McKee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH June 28 1849  
(Month) (Day) (Year)

7 AGE 81 yrs. 3 mos. 14 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER David McKee

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Kean

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Eha McKee

(Address) Cardiff, Ind

15 Filed Oct 13 1923 H. J. McCall  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 12 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 1 1923 to Oct 11 1923

that I last saw him alive on Oct 11 1923

and that death occurred on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH \* was as follows:

P. Paralysis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) H. E. Arthur M.D.

Oct 13 1923 (Address) Cardiff, Ind

\*State the Disease Causing Death, or, if Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL State Ridge (Ind) DATE OF BURIAL Oct 14 1923

20 UNDERTAKER H. W. Holden ADDRESS Delta



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *sc. shoppneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930  
BUREAU V. 8.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

04388

(192)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 182Village or City Bel Air Md (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Kenneth E McKinney

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)single

6 DATE OF BIRTH

Dec 1, 1926  
(Month) (Day) (Year)

7 AGE

23 yrs. 4 mos. 21 ds. or min.?If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)md10 NAME OF  
FATHERVernon Lee McKinney11 BIRTHPLACE  
OF FATHER  
(State or country)md12 MAIDEN NAME  
OF MOTHERAlice M Hare13 BIRTHPLACE  
OF MOTHER  
(State or Country)md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lee McKinney

(Address)

Bel Air md

15

Filed

Apr 23 1930V. E Chambers

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 22, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1928 to Apr, 1927

that I last saw him alive on \_\_\_\_\_, 192\_\_\_\_

and that death occurred on the date stated above, at 4 m.

The CAUSE OF DEATH \* was as follows:

Accidental drowning

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

Apr 23 1930 (Address) Bel Air md M. D.

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parkwood mdApr 24, 1930

20 UNDERTAKER

ADDRESS

Dean Foster Bel Air md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1930  
BUREAU V. S.



MARGIN RESERVED FOR BURNING  
WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WITHIN CORPORATE LIMITS RI

03034

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

PLACE OF DEATH

County

Harford

Village or City

Harvardside (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Eudora M. Hopper

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 SINGLE

MARRIED, WIDOWED OR DIVORCED (Write the word)

widow

6 DATE OF BIRTH

September 14, 1837

(Month)

(Day)

(Year)

7 AGE

92 yrs. 6 mos. 13 ds. or min.?

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Kentucky

10 NAME OF FATHER

Gabriel R. Harvey

11 BIRTHPLACE OF FATHER (State or country)

Kentucky

12 MAIDEN NAME OF MOTHER

Lucretia Bager

13 BIRTHPLACE OF MOTHER (State or Country)

Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Geo. Hopper

(Address)

Harvardside, Md.

15 Filed

Mar. 27 1923

Registrar

16 DATE OF DEATH

3 26 1923

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from 3-21 1920 to 3-26 1920

that I last saw him alive on 3-26 1920

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Mental Degeneration  
Cerebral Degeneration

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) T. M. Steiner M. D.

3-28 1923 (Address) Harvardside, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Angel Hill Cem., Md., 27 1923

20 UNDERTAKER

ADDRESS

Remington House Harvardside, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St. Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent, affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by acetic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR RECORD  
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford

WITHIN CORPORATE LIMITS OF

10484

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Hdelsrace (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Annrie B. McNulty

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE widow  
MARRIED, WIDOWED, OR DIVORCED  
(Write the word)6 DATE OF BIRTH March 24, 1844  
(Month) (Day) (Year)7 AGE 86 yrs. 5 mos. 25 ds. If LESS than 1 day, hrs. or min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife.  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Maryland.10 NAME OF FATHER Peter Brauman11 BIRTHPLACE OF FATHER (State or country) Ireland.12 MAIDEN NAME OF MOTHER Margaret Gallagher13 BIRTHPLACE OF MOTHER (State or Country) Ireland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Abbott  
(Address) Hdelsrace, Md.15 Filed Sept. 22, 1920 Chas. J. Foley, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 19, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept 14<sup>th</sup> 1920 to Sept 19<sup>th</sup> 1920, that I last saw her alive on Sept 19<sup>th</sup> 1920and that death occurred on the date stated above, at 9 P.M.  
The CAUSE OF DEATH \* was as follows:Primary malignant BronchitisContributory Secondary Bronchitis Pneumonia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.(Signed) F. M. Steiner M. D.  
9-21 1920 (Address) Harford, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. John's Cem. DATE OF BURIAL Sept. 23, 192020 UNDERTAKER Pennington & Sons ADDRESS Hdelsrace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicæmia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

BUREAU V



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Oldel Grace, (No. \_\_\_\_\_)

2 FULL NAME John Lee McRoy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widower  
(Write the word)

6 DATE OF BIRTH November 4, 1851  
(Month) (Day) (Year)

7 AGE 79 yrs. — mos. 23 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Salesman  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or Country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Hester L. McRoy

(Address) 2525 Maryland Ave.

15 Filed Nov 30, 1923 Chas. J. Foley, M.D.  
Registrar

13858 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 28, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 23, 1923 to Nov 28, 1923

that I last saw him alive on Nov 28, 1923

and that death occurred on the date stated above, at 3 P.m.

The CAUSE OF DEATH \* was as follows:

Acute nephritis  
Cardiac De-compensation

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) [Signature] M. D.

11-29-1923 (Address) Oldel Grace, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Grove M.E. Cemetery Nov. 30, 1923

20 UNDERTAKER ADDRESS

Remington House Oldel Grace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Oral"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Iamtion," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

04390

44

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

Village or City

Bridgetown (No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Henry Meehan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

June 15 - 1856  
(Month) (Day) (Year)

7 AGE

73 yrs. 10 mos. 10 ds. or min.?

If LESS than  
1 day.....hrs.  
1 day.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Bardonia

(b) General nature of industry, business, or establishment in which employed or (employer)

BTO RR.

9 BIRTHPLACE

(State or country)

Churchville Md.

10 NAME OF FATHER

Peter Meehan

11 BIRTHPLACE OF FATHER

(State or country)

Ireland.

12 MAIDEN NAME OF MOTHER

Mary Martin

13 BIRTHPLACE OF MOTHER

(State or country)

Ireland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Meehan

(Address)

Bridgetown

15

Filed

Sept 24 1920

Registra.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 25, 1920  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Oct 4, 1920, to April 25, 1920.

that I last saw him alive on April 25, 1920.

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH \* was as follows:

Carcinoma Stomach  
Peritonitis Arteriosclerosis

(Duration) yrs. 7 mos. ds.

Contributory  
Secondary

Cardiac Failure

(Duration) yrs. 4 mos. ds.

(Signed)

Charles J. Folger M.D.

4/26

1920 (Address) Churchville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs. mos. ds.

In the State

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Francis Cemetery

April 29, 1920

20 UNDERTAKER

ADDRESS

Howard K. McComas &amp; Sons, Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

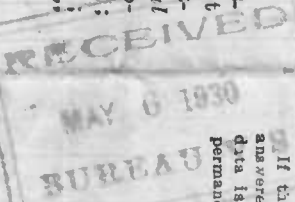
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only, but paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Massanov, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is filed over thoroughly and a question answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.





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## 1 PLACE OF DEATH

County HarfordVillage or City Edgewood Arsenal, (No. ....)  
Md.2 FULL NAME Albert Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
----------------------	---------------------------------	---

6 DATE OF BIRTH

May 19, 1895  
(Month) (Day) (Year)

7 AGE

35 yrs. 0 mos. 20 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Stable Man  
(b) General nature of industry business, or establishment in which employed or (employer) Military  
Edgewood Arsenal, Md.

9 BIRTHPLACE  
(State or country)Pennsylvania

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER  
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or Country)Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Civil Service Records,(Address) Edgewood Arsenal, Md.

15

Filed June 11 1930 Fred Abbott  
local Registrar

06774

(90)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 10, 1930  
June (Month) 10 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
Found dead 192 to 192,that I last saw him alive on 192,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Myocarditis, chronic, degenerative.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
SecondaryArterio Sclerosis, coronary,  
cerebral, and ascending aorta.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) W. A. Hagins Major, M. C. M. D.June 10 1930 WILLIAM A. HAGINS,  
(Address)\*State the disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Edgewood Arsenal,

DATE OF BURIAL

June 12, 1930

20 UNDERTAKER

Howard K. McComas

ADDRESS

Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Broncho pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Harford

Village or City Edgewood (No. \_\_\_\_\_)

2 FULL NAME Julius Welbo Melko

05642 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Dec 15, 1 88  
(Month) (Day) (Year)

7 AGE 48 yrs. 4 mos. 23 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Hungary

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Weeks  
(Address) Edgewood MD

15 Filed May 9 1930 Fred Horlock  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 7, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 2 1930 to May 7 1930,  
that I last saw him alive on May 7 1930,

and that death occurred on the date stated above, at 4:30 P m.  
The CAUSE OF DEATH \* was as follows:

Broncho-Pneumonia  
(Duration) \_\_\_\_ yrs \_\_\_\_ mos 15 ds.

Contributory Secondary Bronchial Asthma  
(Duration) \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.  
(Signed) Chas. R. Rosta M. D.  
May 8 1930 (Address) Edgewood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds. In the State \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Trinity Luthern Cemetery May 10, 1930

20 UNDERTAKER ADDRESS  
Howard K. McComas Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUN 2 1900  
BUREAU V. B.



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## 1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS

10485

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Hdelsrace

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Leila Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 SINGLE

MARRIED, married  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

March 15, 1909  
(Month) (Day) (Year)

7 AGE

21 yrs. 5 mos. 22 ds. or min.?

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

W. Lee Hawkins

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Bertha Fabeley

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Lee Hawkins

(Address)

Hdelsrace, Md.

15 Filed

Sept. 8 1920 Charles J. Foley, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 7, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Aug 25, 1920 to Sept 7, 1920,  
that I last saw him alive on Sept 3, 1920,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

W. Lee Hawkins M. D.  
9-7 1920 (Address) Hdelsrace, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sunrise Chapel Sept. 9, 1920

20 UNDERTAKER

ADDRESS

Perryman, Md.  
Hdelsrace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Needle wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			Registration Dist. No. <u>186</u>	
Village or City <u>Bladesboro</u> (No. _____)			St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mary Mink</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>widow</u>		
6 DATE OF BIRTH <u>August 12, 1850</u> (Month) (Day) (Year)				
7 AGE <u>79</u> yrs. <u>11</u> mos. <u>27</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Ireland</u>				
PARENTS	10 NAME OF FATHER <u>Peter Donovan</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>			
	12 MAIDEN NAME OF MOTHER <u>Mary Flavin</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Ireland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Maggie Green</u> (Address) <u>Bladesboro, Md.</u>				
15 Filed <u>July 6, 1930</u> <u>Chas. J. Foley, M.D.</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>July 5, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 1925</u> to <u>July 5, 1930</u> ; that I last saw him alive on <u>July 5, 1930</u> , and that death occurred on the date stated above, at <u>7:30</u> a.m. The CAUSE OF DEATH * was as follows: <u>Carcinoma Stomach</u> <u>Metastasis</u>				
(Duration) <u>5</u> yrs. <u>0</u> mos. <u>0</u> ds.				
Contributory Secondary <u>Cachexia</u>				
(Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.				
(Signed) <u>Charles J. Foley, M.D.</u> <u>July 5, 1930</u> (Address) <u>Bladesboro, Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Not. Eric Cemetery</u>				DATE OF BURIAL <u>July 7, 1930</u>
20 UNDERTAKER <u>Summington &amp; Son</u>				ADDRESS <u>Bladesboro, Md.</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinney*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For-man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1900  
BUREAU V. S.



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford

15074

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180Village or City Calvary (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alice O. Mitchell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
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6 DATE OF BIRTH <u>July</u> (Month) <u>13</u> (Day) <u>1853</u> (Year)
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7 AGE <u>77</u> yrs. <u>5</u> mos. <u>0</u> ds. or _____ min.?	If LESS than 1 day _____ hrs.
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8 OCCUPATION (a) Trade, profession or particular kind of work <u>House-wife</u> (b) General nature of industry, business, or establishment in which employed or (employer)
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9 BIRTHPLACE (State or country) <u>Maryland</u>
---

10 NAME OF FATHER <u>J. Thomas Gorrell</u>
---

11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
--

12 MAIDEN NAME OF MOTHER <u>Elizabeth Allender</u>
---

13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha Gorrell(Address) Bel Air P.O. Md.15 Filed December 14, 1930 Fred Horlock Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>Dec. 13</u> , 19 <u>30</u> (Month) (Day) (Year)
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17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan. 28</u> , 19 <u>29</u> , to <u>Dec 13</u> , 19 <u>30</u> , that I last saw him alive on <u>Dec 8</u> , 19 <u>30</u>
---

and that death occurred on the date stated above, at 4 A. m.The CAUSE OF DEATH \* was as follows:  
Pulmonary tuberculosis(Duration) 1 yrs. 11 mos. 15 ds.Contributory  
Secondary

(Signed) <u>Chas. H. King</u> M. D. <u>Dec 14</u> , 19 <u>30</u> (Address) <u>Bel Air</u>
--

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL <u>Calvary Cemetery</u>	DATE OF BURIAL <u>Dec 15</u> , 19 <u>30</u>
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20 UNDERTAKER <u>Howard K. McNamee</u>	ADDRESS <u>Abingdon</u>
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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

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BUREAU V. B.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Harford

13859

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 181Village or City Chesden P.F.D. (No. 250)
 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME Margaret B. Mitchell

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

 6 DATE OF BIRTH Sept 9, 1912  
 (Month) (Day) (Year)

 7 AGE 18 yrs. 2 mos. — ds. or — min.?  
 If LESS than 1 day \_\_\_\_ hrs.

 8 OCCUPATION  
 (a) Trade, profession or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

 9 BIRTHPLACE (State or country) Maryland

 10 NAME OF FATHER George W. Mitchell

 11 BIRTHPLACE OF FATHER (State or country) Maryland

 12 MAIDEN NAME OF MOTHER Margaret K. Bechtold

 13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. George W. Mitchell(Address) Chesden P.F.D.15 Filed Nov. 26 1930 G. C. Tucker

Registrar

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH Nov 25, 1930  
 (Month) Nov (Day) 25 (Year) 1930

 17 I HEREBY CERTIFY, That I attended the deceased from April 20, 1930 to Nov 25, 1930  
 that I last saw him alive on Nov 25, 1930

 and that death occurred on the date stated above, at 2:30 P. m.  
 The CAUSE OF DEATH \* was as follows:
Carcinoma Stomach
 Contributory  
 Secondary

 (Duration) 7 yrs. — mos. — ds.  
Exhaustion  
 (Signed) W. S. Tucker M. D.  
Nov 26, 1930 (Address) Chesden P.F.D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

 Former or  
 usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Calvary Cemetery Nov. 27, 1930

20 UNDERTAKER ADDRESS

Henry Janning Son Chesden P.F.D.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Icteric," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Harford

15075

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 181Village or City Near Aberdeen (Non)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mr. Ralph M. Mitchell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
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6 DATE OF BIRTH <u>October 7, 1882</u> (Month) (Day) (Year)
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7 AGE <u>48</u> yrs. <u>2</u> mos. <u>-</u> ds. or <u>-</u> min.?	If LESS than 1 day ____ hrs. or ____ min.?
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## OCCUPATION

(a) Trade, profession or particular kind of work Farmer & Canner  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) Maryland10 NAME OF FATHER Morgan Mitchell11 BIRTHPLACE OF FATHER  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Hannah S. Morgan13 BIRTHPLACE OF MOTHER  
(State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Julian F. Mitchell  
(Address) Aberdeen Md.15 Filed Dec 26 1930 OB Michael  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 23 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192,that I last saw him alive on 192,and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH\* was as follows:

Gunshot wound - Suicide. While temper- arily deranged.

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary(Signed) S. D. McGuigan & P. Paul Connor M. D.  
Dec 24 1930 (Address) Bethesda Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove Cemetery Dec 26 1930

20 UNDERTAKER

ADDRESS

Henry Fanning Son Aberdeen Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Harre de la Noe Hospital

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mrs. Sarah J. Mitchell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED, Married

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

June

16

1860

(Month)

(Day)

(Year)

7 AGE

70 yrs.

1 mos.

ds.

If LESS than

1 day.....hrs.

or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF

FATHER

Henry Cantler

11 BIRTHPLACE

OF FATHER

(State or country)

Maryland

12 MAIDEN NAME

OF MOTHER

Amanda Richie

13 BIRTHPLACE

OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Chas. H. Mitchell

(Address)

Cherden R.F.D.

15

Filed

July 21 1930

Chas. J. Foley, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

20

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY That I attended the deceased from

July 10

1920 to

July 20

1920

that I last saw him alive on

July 19

1920

and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH \* was as follows:

Thymic Neoplasm  
Hypertension

(Duration).....yrs.....mos.....ds.

Contributory

Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

R. S. Lewis, M.D.

7-21

1930 (Address)

Harre de la Noe

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.....mos.....ds.

In the

State

yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rock Run Cemetery

July 22, 1930

20 UNDERTAKER

ADDRESS

Henry Tanning &amp; Cherden

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, tetanocæm, etc., Carcinoma, Sarcoma, etc.*, ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Rocks (No.     ), St.      Ward     Registration Dist. No. 183

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Keneth Nello Monks

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)
----------------------	---------------------------------	---

6 DATE OF BIRTH

Nov. 30 1930

(Month) (Day) (Year)

7 AGE

0 yrs. 0 mos. 0 ds. or      min. ?If LESS than  
1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work None(b) General nature of industry business, or establishment in which employed or (employer) None

9 BIRTHPLACE

(State or country)

Harford C. Md.

10 NAME OF FATHER

Frederick N. Monks

11 BIRTHPLACE OF FATHER

(State or country) Harford C. Md.

12 MAIDEN NAME OF MOTHER

Pearl May Marton

13 BIRTHPLACE OF MOTHER

(State or country) Penna

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick N. Monks(Address) Rocks, Md.

15

Filed Dec 1 1930 Thomas R. Brown  
Registrar14235 STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 30, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased fromat birth, 192...  
that I last saw him alive on, 192...and that death occurred on the date stated above, at      m.

The CAUSE OF DEATH was as follows:

StillbornContributory  
Secondary(Duration)      yrs.      mos.      ds.(Signed) H. E. Arthur M. D.Dec 1st, 1930 (Address) Camdelford

\*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death      yrs.      mos.      ds. In the State,      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

North Bend Cem. Dec. 1, 1930

20 UNDERTAKER ADDRESS

E. G. Kurtz & Son Jarrettsville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

RECEIVED

JAN 2 1931

BUREAU

"unqualified, is indefinite"); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Tracoma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Harford

12873 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

Village or City Womels (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Richard McClure Moore

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Sept 13, 1873  
(Month) (Day) (Year)

7 AGE 57 yrs. 1 mos. 17 ds. or 1 day 17 hrs. min. If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John H. Weston

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Buck Moore

(Address) Womels Md

15 Filed Nov 1, 1930 Fred Abbarlak Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 25, 1930 to Oct 30, 1930, that I last saw him alive on Oct 30, 1930

and that death occurred on the date stated above, at 10:15 m. The CAUSE OF DEATH \* was as follows:

Polar Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.

Contributory Secondary \_\_\_\_\_

(Signed) Chas R. Roth M. D. Oct 30, 1930 (Address) Edgewood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Church of the Holy Trinity, Baltimore, Md DATE OF BURIAL Nov 1, 1930

20 Howard R. McConner ADDRESS Abingdon Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 3 1930



MARGIN RESERVED FOR RECORDING  
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Harford,

WITH CORPORATE LIMITS

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

Hdelsboro,

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Julia Ann Moser,

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female colored

4 COLOR OR RACE

5 SINGLE  
MARRIED widow  
WIDOWED.  
OR-DIVORCED  
(Write the word)

6 DATE OF BIRTH

unknown

(Month)

(Day)

(Year)

7 AGE

alt 72 yrs. - mos. - ds. or min.?

If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housework.

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Maryland

10 NAME OF FATHER

Lewis Pinion

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Henrietta Nease

13 BIRTHPLACE OF MOTHER  
(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mary Durlin

(Address)

Hdelsboro, Md.

15 Filed

July 12 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 9, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 30, 1930, to July 9, 1930.

that I last saw her alive on July 9, 1930.

and that death occurred on the date stated above, at 10 PM m.  
The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 10 ds.

Contributory  
Secondary

Dobson

(Duration) yrs. mos. ds.

(Signed)

F. W. Steiner, M. D.

7-11-1930 (Address) Farn &amp; Franklin

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gravelly Hill

July 12, 1930.

20 UNDERTAKER

ADDRESS

Perrington &amp; Son Hdelsboro, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rebuckler wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordWITHIN CORPORATE LIMITS OF  
(49)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Harre de Grace (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mildred L. Mouldsdale

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH <u>April 4, 1926</u> (Month) (Day) (Year)
---

7 AGE <u>4 yrs. 5 mos. — ds. or min.</u>	If LESS than 1 day hrs.
---	-------------------------

8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)	<u>None</u>
--	-------------

9 BIRTHPLACE (State or country)	<u>Maryland</u>
---------------------------------	-----------------

10 NAME OF FATHER	<u>George F. Mouldsdale</u>
-------------------	-----------------------------

11 BIRTHPLACE OF FATHER (State or country)	<u>Maryland</u>
--	-----------------

12 MAIDEN NAME OF MOTHER	<u>Bearl Thompson</u>
--------------------------	-----------------------

13 BIRTHPLACE OF MOTHER (State or Country)	<u>Maryland</u>
--	-----------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. George F. Mouldsdale(Address) Harre de Grace Md15 Filed Sept 22 1923 Charles J. Foley M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 21<sup>st</sup>, 1923  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 1<sup>st</sup>, 1923 to Sept 21<sup>st</sup>, 1923, that I last saw him alive on Sept 21<sup>st</sup>, 1923,and that death occurred on the date stated above, at 11:35 P. M.  
The CAUSE OF DEATH \* was as follows:Simple Cell Carcinoma of Spleen  
(Duration) yrs. 3 mos. ds.Contributory Secondary Exhaustion  
(Duration) yrs. mos. ds.(Signed) J. N. Steiner M. D.  
Sept 21<sup>st</sup>, 1923 (Address) J. N. Steiner

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bahus Cemetery Sept. 23, 1923

20 UNDERTAKER ADDRESS

Henry Tarrington Chesapeake Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
OCT 6 1930  
BUR



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Rock Run (No. \_\_\_\_\_)

2 FULL NAME Emma Mustard

03036

(90)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 181

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Sept. 22, 1888  
(Month) (Day) (Year)

7 AGE 41 yrs. 5 mos. 19 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER John Lee

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Leila Branson

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Mark Mustard  
(Address) Rock Run, Md.

15 Filed Mar. 16, 1930 Bert B. Knight  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 12, 1930 to March 14, 1930, that I last saw her alive on March 14, 1930, and that death occurred on the date stated above, at 9 30 p.m.  
The CAUSE OF DEATH \* was as follows:

Mitral Regurgitation  
of heart

(Duration) 10 yrs. mos. \_\_\_\_ ds. \_\_\_\_  
Contributory Secondary Rheumatism

(Signed) H. P. Snodgrass M. D.  
3/15, 1930 (Address) Washington

\*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Rock Run, Md. DATE OF BURIAL March 17, 1930

20 UNDERTAKER Levinson & Son, Oldesburg, Md. ADDRESS \_\_\_\_\_



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Cool mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonoeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Truemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
APR 7 1908  
BUREAU



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1 PLACE OF DEATH County <u>Harford</u>			155643 WITHIN CORPORATE LIMITS OF 90			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Harred Grace</u> (No. <u>212 N. Stokes</u> )			St. _____ Ward _____			Registration Dist. No. <u>185</u>		
2 FULL NAME <u>Andrew Myers</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Male</u>		4 COLOR OR RACE <u>White</u>		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>				
6 DATE OF BIRTH <u>Sept 2</u> , 1880 (Month) (Day) (Year)				16 DATE OF DEATH <u>May 5</u> , 1930 (Month) (Day) (Year)				
7 AGE <u>49</u> yrs. <u>3</u> mos. <u>3</u> ds. or min.?				17 I HEREBY CERTIFY, That I attended the deceased from <u>May 1</u> , 1930, to <u>May 5</u> , 1930 that I last saw him alive on <u>May 5</u> , 1930 and that death occurred on the date stated above, at <u>6 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Valvular Disease of Heart, Mitral Stenosis</u> (Duration) _____ yrs. _____ mos. <u>5</u> ds. Contributory <u>Cardiac Failure</u> Secondary _____ (Signed) <u>Charles J. Foley</u> M. D. <u>5/6</u> , 1930 (Address) <u>Harred Grace, Md.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Carpenter</u> (b) General nature of industry business, or establishment in which employed or (employer) _____				18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
9 BIRTHPLACE (State or country) <u>Md.</u>				19 PLACE OF BURIAL OR REMOVAL <u>Wesleyan Chapel</u>				
10 NAME OF FATHER <u>Unknown</u>				DATE OF BURIAL <u>May 9</u> , 1930				
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>				20 UNDERTAKER <u>P. Madison Mitchell</u>				
12 MAIDEN NAME OF MOTHER <u>Unknown</u>				ADDRESS <u>Harred Grace, Md.</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Lillian A. Bryant</u> (Address) <u>212 N. Stokes St.</u>								
15 Filed <u>May 8</u> , 1930 <u>Chas. J. Foley, M.D.</u> Registrar								



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tuenia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Hanover

Village or City Bel Air (No. \_\_\_\_\_)

2 FULL NAME Annie M. Nagle

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH July 17, 1882  
(Month) (Day) (Year)

7 AGE 48 yrs. 3 mos. 8 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House duties  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Calvin Bond

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Mary Ely

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Eliz Debow  
(Address) Bel Air md

15 Filed June 27, 1930, H. C. Chambers  
Deputy Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Garrett S. Nagle

06775

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 25, 1930  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended the deceased from June 4<sup>th</sup> 1930 to June 25<sup>th</sup> 1930, that I last saw her alive on June 25<sup>th</sup> 1930.

and that death occurred on the date stated above, at 2<sup>15</sup> P. M.  
The CAUSE OF DEATH \* was as follows:

Carcinoma of uterus  
(Duration) unknown

Contributory  
Secondary

(Signed) A. F. Van Bibber M. D.  
June 26<sup>th</sup> 1930 (Address) Bel Air, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Met Zion Cemetery DATE OF BURIAL June 27, 1930  
20 UNDERTAKER Dean & Foster ADDRESS Bel Air, Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 3 1930  
BUREAU OF  
VITAL STATISTICS



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

Village or City

Bellevue

(No. ....)

St. .... Ward)

Registration Dist. No.

182

2 FULL NAME

Charles Lee Nelson

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

single

6 DATE OF BIRTH

Mar 23, 1929  
(Month) (Day) (Year)

7 AGE

11 yrs. 11 mos. ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Md

10 NAME OF  
FATHER

Lester L Nelson

11 BIRTHPLACE  
OF FATHER  
(State or country)

Va

12 MAIDEN NAME  
OF MOTHER

Mora Bellings

13 BIRTHPLACE  
OF MOTHER  
(State or country)

N.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lester L Nelson

(Address)

Bel Air Md

15

Filed Feb 28, 1930

M. E. Richardson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 28, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
Feb 9, 1930 to Feb 27, 1930,

that I last saw him alive on Feb 27, 1930,

and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH \* was as follows:

Bronchitis pneumonia  
Secondary to acute tonsillitis  
+ Bronchitis

(Duration) yrs. mos. 9 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) W. P. Nelson M. D.

Feb 28, 1930 (Address) Forest Hill Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Zion Cemetery

Mar 1, 1930

20 UNDERTAKER

ADDRESS

Dean Taylor

Bel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Artist, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 6 1906

BUREAU OF



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford.

04391

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

Village or City Van Bibber. (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Susan Nichols.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>
6 DATE OF BIRTH <u>1861</u> (Month) (Day) (Year)		
7 AGE <u>69</u> yrs. ____ mos. ____ ds. or ____ min.?		
8 OCCUPATION (a) Trade, profession or particular kind of work. <u>none</u> (b) General nature of industry business, or establishment in which employed or (employer) _____		
9 BIRTHPLACE (State or country) <u>Md.</u>		
10 NAME OF FATHER <u>Lewis Peaker.</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>		
12 MAIDEN NAME OF MOTHER <u>Annie Hops.</u>		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie Lingham.

(Address) Aboigdon, Md.

15 Filed April 6, 1930 Fred McLaughlin  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 3, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 31 1930 to Apr 3, 1930, that I last saw him alive on Mar 31, 1930, and that death occurred on the date stated above, at 40 m. The CAUSE OF DEATH \* was as follows:

Myocardial Insufficiency  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Chas. E. Port M. D.  
Apr 4 1930 (Address) Edgewood

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

John Wesley Cemetery.

April 6, 1930

20 UNDERTAKER

ADDRESS

Howard H. McLaughlin Aboigdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia."); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Iatinition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 3 1930  
BUREAU OF VITALS



MARGIN RESERVED FOR RECORDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Harford

0518

159-2

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

Village or City Stevenson Md. (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alice Christine Odegard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec 31, 1929  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Edward Odegard

11 BIRTHPLACE OF FATHER (State or country) Norway

12 MAIDEN NAME OF MOTHER Louise Hoops

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. S. Hoops

(Address) Stevenson Md.

15 Filed Jan 2, 1930 H. J. McNabb Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 1st, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 31st, 1929 to Jan 1st, 1930.

that I last saw her alive on Jan 1st, 1930.

and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH \* was as follows:

Convulsions (Blue baby)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. E. Arthur M. D.

Jan 2, 1930 (Address) Goodf. Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

State Ridge Cemetery, Pa. Jan 3, 1930

20 UNDERTAKER ADDRESS

H. K. Webb Edison Ave

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

V. S. No. 1

T



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 6 1930



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hartford

Village or City Otter Point (No. \_\_\_\_\_)

2 FULL NAME GEORGE P. ODQUIST

09336 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct. 20, 1907  
(Month) (Day) (Year)

7 AGE 22 2/3 yrs. 10 mos. 20 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Clerk  
(b) General nature of industry, business, or establishment in which employed or (employer) Newspaper

9 BIRTHPLACE (State or country) MINNESOTA

10 NAME OF FATHER C. D. ODQUIST

11 BIRTHPLACE OF FATHER (State or country) SWEDEN

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Guy S. Skusser

(Address) 2121 N. Y. Ave. Wash. DC

15 Filed Aug. 12, 1930 Fred Aborlok Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 10, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_, 192\_\_\_\_ to \_\_\_\_\_, 192\_\_\_\_.

that I last saw him alive on \_\_\_\_\_, 192\_\_\_\_.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Accidental Drowning in Bush River, near Otter Point, Verdict of Coroner's jury

Contributory \_\_\_\_\_ Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Fred Aborlok, Coroner  
Aug. 11, 1930 (Address) Abingdon, Md

\*State the Disease Causing Death or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Hutchinson, Minn. DATE OF BURIAL Aug 12, 1930

20 UNDERTAKER Howard K. McComas, ADDRESS Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 3 1930  
BUREAU OF VITALS



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Harford*

WITHIN CORPORATE LIMITS OF

12506

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *185*Village or City *Hdelsrace* (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Mary E. Osmond*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female white*

4 COLOR OR RACE

5 SINGLE

*Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

*April 14, 1852*  
(Month) (Day) (Year)

7 AGE

*78 yrs. 6 mos. 5 ds.*  
If LESS than 1 day... hrs. or... min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Maryland*

10 NAME OF FATHER

*Jacob Osmond*

11 BIRTHPLACE OF FATHER

(State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Elizabeth Johnson*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*D. M. Osmond*

(Address)

*Hdelsrace, Md.*

15

Filed

*Oct. 23 1930 Charles J. Foley*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Oct 20th, 1930*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *July 1st, 1930* to *Oct 20th, 1930*that I last saw him alive on *Oct 17th, 1930*and that death occurred on the date stated above, at *9 P. m.*

The CAUSE OF DEATH \* was as follows:

*Carcinoma of breast (left)**Unlunon* (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

*J. L. Hopkins*

M. D.

*Oct 22 1930*

(Address)

*Howe de Sees*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the

State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Angel Hill Cem.**Oct. 23, 1930*

20 UNDERTAKER

ADDRESS

*Pennington & Son**Hdelsrace, Md.*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Harford

Village or City Hublin (No. —)

2 FULL NAME G. R. Ostrander

15076

(90)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 184

St. — Ward — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH April 3, 1853  
(Month) (Day) (Year)

7 AGE 77 yrs. 8 mos. 25 ds. or — min. If LESS than 1 day — hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Pa.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mrs. Brown

13 BIRTHPLACE OF MOTHER (State or Country) New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Josie Pace Ostrander  
(Address) Strut, Md.

15 Filed Dec 29 1930 M. H. T. H. C.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 1, 1930 to Dec 28, 1930

that I last saw him alive on Dec 28, 1930

and that death occurred on the date stated above, at 11 A. m.

The CAUSE OF DEATH \* was as follows:

Apoplexy

Contributory (Duration) yrs. mos. 2 yrs. — mos. — ds.  
Secondary Arteriosclerosis and  
neural degeneration

(Signed) P. P. Snodgrass M. D.  
Dec 28, 1930 (Address) Washington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Martinsville, Va. DATE OF BURIAL Dec 29, 1930

20 UNDERTAKER H. S. Bailey ADDRESS Washington, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 9 1931

B



MARGIN RESERVED FOR RECORD  
 ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Harford

WITHIN CORPORATE LIMITS OF

16487

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Hd Grace (No. Hospital St. W. Plumer Owens Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
 (Write the word)

6 DATE OF BIRTH Unknown 1 (Month) (Day) (Year)

7 AGE alt. 33 yrs. - mos. - ds. or min. If LESS than 1 day, hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Painter - (b) General nature of industry, business, or establishment in which employed or (employer) House -

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER William P. Owens

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. L. L. Chance(Address) Hd Grace, Md.

15 Filed Oct. 1, 1930 Charles J. Foley, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 30, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept. 1930 to Sept. 1930, that I last saw him alive on Sept. 1930,

and that death occurred on the date stated above, at 11 m.

The CAUSE OF DEATH \* was as follows:

Acute Alcoholism  
Delirium Tremens

Contributory (Duration) Cardiac Failure yrs. mos. ds.

(Signed) Martin P. Foley, Coroner M. D. Sept 30, 1930 (Address) Hd Grace Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 mos. yrs. mos. ds. In the State 4 mos. yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Hd Grace

19 PLACE OF BURIAL OR REMOVAL Ashbury Cecil Co. DATE OF BURIAL Oct. 2, 1930

20 UNDERTAKER Summington & Son Hd Grace, Md. ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

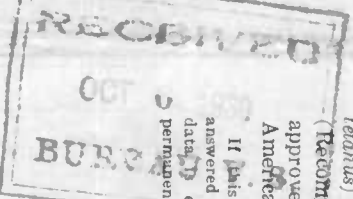
(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Coremia, Sorema, etc., of* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

*Harford*

04392

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

185

Village or City

*Name de Grace, Md.*

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Mike Miller (Mike Pabajurski)*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

*Married*

6 DATE OF BIRTH

*Unknown*

(Month)

(Day)

(Year)

7 AGE

*Att. 60*

yrs.

mos.

da.

or min. ?

If LESS than  
1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Labor*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Poland*

10 NAME OF FATHER

*Mike Pabajurski*

11 BIRTHPLACE OF FATHER

(State or country)

*Poland*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER

(State or country)

*Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*John M. Weber*

(Address)

*Baltimore, Md.*

15

Filed

*Apr. 22, 1930**Chas. J. Foley, M.D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*April 22, 1930*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

*Apr. 21, 1930, to Apr. 22, 1930*that I last saw him alive on *1930*and that death occurred on the date stated above, at *7 P.M.*

The CAUSE OF DEATH was as follows:

*Old age shock fracture of both legs*Contributory  
Secondary*Struck by Automobile*(Signed) *Martin P. Foley "Coroner"* M.D.*April 22, 1930* (Address) *Name de Grace, Md.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .... yrs. .... mos. .... da. In the State, .... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Holy Rosary Cem.**Apr. 25, 1930*

20 UNDERTAKER

ADDRESS

*John M. Weber**Balto., Md.*



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(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.** Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Soldier*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Stomach*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meninges*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary condition, such as "Asbestosis," "Anæmia" (merely symptomatic), "Atrophy," "Collapsus," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Emaciation," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Pneumia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (It commentary on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data essential and must be obtained before the certificate is filed.

U. S. DEPT. OF COMMERCE  
DIVISION OF LABOR  
038162 ADV  
JUL 1 1914



MARGIN RESERVED FOR RECORDING  
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

0519

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

Village or City Abingdon (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Katrinka Pacholik

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Feb 2, 1 861  
(Month) (Day) (Year)

7 AGE 68 yrs. 11 mos. 8 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Czechoslovakia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Czechoslovakia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Czechoslovakia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Pacholik

(Address) Abingdon

15 Filed Jan 27 1930 Fred H. Clark Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 21 1930 to Jan 25 1930, that I last saw him alive on Jan 24, 1930, and that death occurred on the date stated above, at 10 4 m.

The CAUSE OF DEATH \* was as follows:

Thoracic-Pneumonia

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 5 ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Chas. R. R. R. M. D.  
Jan 25 1930 (Address) Edgewood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Hill Cemetery

Jan. 28, 1930

20 UNDERTAKER

ADDRESS

Howard K. McComas

Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plunker, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictition," "Marsasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leuæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1930  
BUREAU U. S.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

01740

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

181

Village or City

Bel Air R.F.D.#1

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Sarah E. Page

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow
-----------------	--------------------------	--

6 DATE OF BIRTH

April 12, 1845  
(Month) (Day) (Year)

7 AGE

84 yrs. 109 mos. 15 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Daniel Tallinger

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Hyzkins

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert M. Page

(Address)

Bel Air R.F.D.#1

15 Filed

Mar 1 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Jan 1927 to Feb 28, 1930  
that I last saw her alive on Feb 7, 1930

and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH \* was as follows:

Myo-carditis &  
Endo-carditis

(Duration) 3 yrs. mos. ds.

Contributory  
Secondary

(Duration) 4 yrs. mos. ds.

(Signed) M. D. Hyzkins  
Feb 28, 1930. (Address) Bel Air Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rock Run Cemetery March 1, 1930

20 UNDERTAKER

ADDRESS

Henry Tarning Sons Aberdeen Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. 2



N. E.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Hager

WITHIN CORPORATE LIMITS OF

09337

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Hagerstown (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Robert Palmer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, Single  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH unknown, 1 \_\_\_\_\_  
(Month) (Day) (Year)

7 AGE 44 70 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pa

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or Country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hagerstown Grace Hospital(Address) Hagerstown, Md15 Filed Aug 28 1920 by J. T. Lohr, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 27, 1920.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from August 16, 1920, to August 27, 1920, that I last saw him alive on August 27, 1920, and that death occurred on the date stated above, at 7:30 p.m. The CAUSE OF DEATH \* was as follows:

Brain Concussion & Shock

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory Struck by Automobile  
Secondary \_\_\_\_\_

(Signed) J. L. Hopkins M. D.  
Aug 27 1920 (Address) Hagerstown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or present residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morgan Farm Cem Aug 29, 192020 UNDERTAKER Harford Co. ADDRESSLee A. Patterson Cerryville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Harford

09338

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 184Village or City Cardiff (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Parthre

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Aug 4, 1930  
(Month) (Day) (Year)

7 AGE

If LESS than  
1 day, 1 hr.  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or 10 min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE

(State or country)

Cardiff, Harford Co Md.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Aug 4 - 1930 H. J. S. McNabb  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 4, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended the deceased from

at birth, 192that I last saw him alive on Aug 4, 1930and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH \* was as follows:

Premature child  
(specify months)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Dr. E. Arthur M. D.Aug 4, 1930 (Address) Cardiff Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salem Conn.

20 UNDERTAKER

ADDRESS

Mrs. Olive Parthre & Wm ParthreDelta, Pa.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (c) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DIS-EASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever*—(never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Starford

Village or City Hublin (No.     )

2 FULL NAME Laura J. Payne

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 ~~SINGLE~~ MARRIED Married  
~~WIDOWED~~  
~~UNMARRIED~~ (Write the word)

6 DATE OF BIRTH March 9, 1866  
(Month) (Day) (Year)

7 AGE 64 yrs. 6 mos. 25 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry business, or establishment in which employed or (employer)     

9 BIRTHPLACE (State or country) Var.

10 NAME OF FATHER Ellis Leftwich

11 BIRTHPLACE OF FATHER (State or country) Var.

12 MAIDEN NAME OF MOTHER Anora Hill

13 BIRTHPLACE OF MOTHER (State or Country) Var.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mylie Leonard  
(Address) Street, Md. Bkto.

15 Filed Oct 4 1923 M. R. Ruck  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 4, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 10, 1920 to Oct 4, 1923

that I last saw her alive on Sept. 25, 1923

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH \* was as follows:  
Coronary Heart Disease

Contributory Secondary (Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Charles W. Brown M. D.  
Oct 4, 1923 (Address) Street Bkto.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?     

Former or usual residence     

19 PLACE OF BURIAL OR REMOVAL Highland Cem. DATE OF BURIAL Oct 7, 1923

20 UNDERTAKER H. S. Bailey ADDRESS Marlington



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. **Examples:** (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup Typhoid fever (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Apæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haemion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 6 1900

BUREAU



MARGIN RESERVED FOR FUNDING  
WRITE EARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Abingdon (No. \_\_\_\_\_)

2 FULL NAME Rakus

04393

(8)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Apr 19, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Samuel Rakus

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gerardine Beasley

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gerardine Rakus

(Address) Abingdon

15 Filed April 30 1930 Friedelhorst local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 19, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 19230 to \_\_\_\_\_ 19230

that I last saw him alive on \_\_\_\_\_ 19230

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Prmature Birth  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary \_\_\_\_\_

(Signed) Charles R. Ederwood M. D.  
Apr 19 19230 (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

John Wesley Cemetery April 20, 1930

20 UNDERTAKER

ADDRESS

Father of Child Abingdon Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*, *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Harford

10488

(168)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 183Village or City Near Shane (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup>FULL NAME Walter Pearson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH .....  
(Month) (Day) (Year)

7 AGE ..... If LESS than 1 day ..... hrs. 1 day ..... hrs. 1 day ..... hrs.  
About 45 yrs. .... mos. .... ds. or ..... min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Baltimore City

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (State or country) Not known

12 MAIDEN NAME OF MOTHER Fannie Pearson

13 BIRTHPLACE OF MOTHER (State or country) Balto. City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Pearson(Address) White Hall Md.

15 Filed Sept 29 1930 Thomas R. Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192, that I last saw him alive on 192, and that death occurred on the date stated above, at .....

The CAUSE OF DEATH \* was as follows:  
Saw him after death  
Suicide by Hanging  
(Duration) yrs. .... mos. .... ds.

Contributory  
Secondary

(Signed) Dr. J. J. Lee M. D.  
Oct 1st 1930 (Address) Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cedar Hill Cem. Sept 30 1930

20 UNDERTAKER ADDRESS

E. G. Kurtz & Son Jarrettsville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Tailor," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 7 1900

BUREAU



STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

## PLACE OF DEATH

County HarfordVillage or City Harre de Grace, Md. (No. 110 St. Washington St.: \_\_\_\_\_ Ward) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Dr. Lee Roberts Pennington

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 ~~SINGLE,~~ Married  
~~MARRIED,~~  
~~WIDOWED,~~  
~~OR DIVORCED~~  
(Write the word)6 DATE OF BIRTH July 13, 1864  
(Month) (Day) (Year)7 AGE 65 yrs. 8 mos. 26 da. or min. ?  
If LESS than 1 day... hrs.

## OCCUPATION

(a) Trade, profession or particular kind of work Dentist  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

## 8 BIRTHPLACE

(State or country) Maryland

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country) Maryland

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Lavine Pennington(Address) 110 St. Washington St.Filed Apr. 10 1930 Chas. J. Foley, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 9, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 4th 1930, to April 9 1930  
that I last saw him alive on April 9 1930  
and that death occurred on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH was as follows:

Lobar PneumoniaContributory  
Secondary(Duration) 6 mos. 6 da.  
Influenza  
(Signed) J. Lee Hopkins M.D.  
Apr. 9 1930 (Address) Harre de Grace, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 6 yrs. 8 mos. 26 da. In the State, 6 yrs. 8 mos. 26 da.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

Angel Hill Cem.

## DATE OF BURIAL

Apr. 11 1930

## 20 UNDERTAKER

R. Madison Mitchell

## ADDRESS

Harre de Grace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningea, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal condition, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal, septicaemia," "Prenatal, peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (For recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 5 1930  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

WITHIN CORPORATE LIMITS OF

03037

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City

(No. 622 Fountain)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Feb.

16

1867

(Month)

(Day)

(Year)

7 AGE

63 yrs.

mos.

ds.

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

House Duties

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF

FATHER

Franklin D. Pearson

11 BIRTHPLACE

OF FATHER

(State or country)

N. C.

12 MAIDEN NAME

OF MOTHER

Sussannah Cook

13 BIRTHPLACE

OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Geo. Pfaffentach

(Address)

622 Fountain St.

15 Filed

Mar. 18 1930

Chas. J. Foley, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 17, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

192

to

192

that I last saw her alive on

Mar

1930

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH \* was as follows:

Acute Nephritis  
urinary Cause

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

Violent Cause

(Duration)

yrs.

mos.

ds.

(Signed)

J. L. Hopkins

M. D.

(Address)

Harold St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Angel Hill Cem

Mar. 19, 1930

20 UNDERTAKER

ADDRESS

P. Madison Mitchell Harrod Grace



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mastitis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
APR 9 1920  
BUREAU OF VITAL STATISTICS



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

03038 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City Forest Hill (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Infant Poole

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH Mar 11, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day — hrs. or — min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Chas W. Poole

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER E Helen K Webster

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas W Poole  
(Address) Forest Hill

15 Filed Mar 11 1930 N E Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 11, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on \_\_\_\_\_, 192

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH was as follows:

Dead born  
4 days at birth  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Prinell S. Safford M.D.  
Mar 11 1930 (Address) Bell Air

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Mary's Mar 12, 1930

20 UNDERTAKER ADDRESS

Deann T. Foster Bell Air, md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *A accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.







# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rebeller wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 3 1905  
BUREAU



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

Village or City

Castleton (No. \_\_\_\_\_)

2 FULL NAME

Martha E. Presberry

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

April 3 1919  
(Month) (Day) (Year)

7 AGE

10 yrs. 11 mos. 12 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

School girl

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Allen Presberry

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Daisy Horsey

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Allen Presberry

(Address)

Darlington Md.

15 Filed

March 15 1930 M. H. Kirk

Registrar

03039

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mch. 15 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mch. 12 1930 to Mch. 15 1930

that I last saw her alive on Mch. 13 1930

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH \* was as follows:

acute endocarditis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) W. E. Gallin M. D.

Mch. 16 1930 (Address) Darlington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hosanna Cem. March 18, 1930

20 UNDERTAKER

ADDRESS

H. S. Bailey Darlington

Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Teacher," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *other pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.,* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic interstitial heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemic" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling tree; accidental Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

APR 8 1910  
BUREAU OF VITALS



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u>			04396 STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Castleton</u> (No. <u>      </u> )			Registration Dist. No. <u>184</u>		
2 FULL NAME <u>Oscar Prigg</u>			St. <u>      </u> Ward <u>      </u> (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, <u>Married</u> <del>WIDOWED</del> OR <del>DIVORCED</del> (Write the word)			
6 DATE OF BIRTH <u>Dec 28 1882</u> (Month) (Day) (Year)					
7 AGE <u>47</u> yrs. <u>3</u> mos. <u>7</u> ds. or <u>      </u> min. If LESS than 1 day <u>      </u> hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>In Coal yard</u>					
9 BIRTHPLACE (State or country) <u>Md.</u>					
PARENTS	10 NAME OF FATHER <u>Horace Prigg</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Louisa Spriggs</u>				
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lewis F. Prigg</u> (Address) <u>235 Chestnut Ave. Baltimore</u>					
15 Filed <u>April 16 1923</u> <u>M. W. Kink</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>April 6</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 19</u> , 19 <u>29</u> to <u>April 6</u> , 19 <u>30</u> , that I last saw him alive on <u>April 4</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>10 9</u> m. The CAUSE OF DEATH * was as follows: <u>apoplexy</u> (Duration) <u>2</u> yrs. <u>2</u> mos. <u>      </u> ds.					
Contributory Secondary (Duration) <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.					
(Signed) <u>W. E. Calloway</u> M. D. <u>4-6</u> 19 <u>30</u> (Address) <u>Washington</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u>      </u>					
19 PLACE OF BURIAL OR REMOVAL <u>Md. Horanna Cem</u> DATE OF BURIAL <u>April 9, 1930</u>					
20 UNDERTAKER <u>A. S. Bailey</u> ADDRESS <u>Washington, Md.</u>					
If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.					



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The maternal worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia",

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*, *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 8 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

Village or City

Jeffers Road

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ida May Proctor

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Dec 10, 1861

7 AGE

68 yrs. 11 ds. or min.?

If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Harford Co. Md.

10 NAME OF FATHER

Stewart Boutwell

11 BIRTHPLACE OF FATHER

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Ellen Famous

13 BIRTHPLACE OF MOTHER

(State or country)

Harford Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. M. Proctor

(Address)

Jeffers Road

15

Filed Dec 11, 1920

Registral

16 DATE OF DEATH

Nov 29, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Nov. 26, 1930, to Nov. 29, 1930,

that I last saw him alive on Nov. 29, 1930

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

Contributory Secondary

(Signed)

Wm. L. Stuber M. D.

Nov 29, 1930 (Address) Red Bank, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Providence M. F. Dec 2, 1930

20 UNDERTAKER

ADDRESS

Boutwell &amp; Geo. Benson, Inc.

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, House-keeper, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Reckless wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU



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1 PLACE OF DEATH  
County Harford

WITHIN CORPORATE LIMITS OF

03040

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Edel Grace (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Josephine Prounties

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH June 28, 1929  
(Month) (Day) (Year)

7 AGE 8 yrs. 11 mos. 11 ds. or 11 min. 2

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Angelo Prounties

11 BIRTHPLACE OF FATHER (State or country) Italy

12 MAIDEN NAME OF MOTHER Florence Jennings

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Prounties  
(Address) Edel Grace, Md.

15 Filed Mar. 12, 1930 Geo. J. Foley, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 12, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 24, 1930, to March 12, 1930.

that I last saw her alive on March 11, 1930.

and that death occurred on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH \* was as follows:

Whooping Cough

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory Secondary Broncho Pneumonia

(Signed) W. H. Stein M. D.  
March 12, 1930 (Address) Harbor Road

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Hopewell Cem. DATE OF BURIAL March 13, 1930

20 UNDERTAKER Remington & Son ADDRESS Edel Grace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b)  *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Nervant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicæmia*, "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 5 1930

BUREAU



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1 PLACE OF DEATH  
County Starford

Village or City Seewege (No. \_\_\_\_\_)

2 FULL NAME Florence Estelle Rateleffe

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH July 17, 1866  
(Month) (Day) (Year)

7 AGE 64 yrs. 1 mos. 4 ds. IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Balto Md

10 NAME OF FATHER Adam Offner

11 BIRTHPLACE OF FATHER (State or country) France

12 MAIDEN NAME OF MOTHER Christine Dross

13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence Rateleffe  
(Address) 4006 Clifton Ave

15 Filed Aug 23, 1930 Fred. H. H. H. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That deceased Aug. 21, 1930 and found her dead. My examination of the body and my investigations con- firm me that she had been alive on Aug. 21, 1930 and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

(Duration) a few minutes yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) A. F. Van Bibber M. D.  
Aug. 23, 1930 (Address) Bel Air, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL  
Loudon Park Cemetery

DATE OF BURIAL  
August 23, 1930

20 UNDERTAKER  
Howard K. McComas,

ADDRESS  
Abingdon, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 3 1930  
BUREAU U. S.



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## PLACE OF DEATH

County

Harford

Village or City

Aberdeen

(No. X)

2 FULL NAME

William Hicks Rawhouser

15077

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 2, 181

St. X Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widower

6 DATE OF BIRTH

Dec -

17

1854

(Month)

(Day)

(Year)

7 AGE

76 yrs.

mos.

14 ds.

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired Farmer

(b) General nature of industry, business, or establishment in which employed or (employer)

Retired

9 BIRTHPLACE

(State or country)

Aberdeen Md.

10 NAME OF FATHER

Joshua Rawhouser

11 BIRTHPLACE OF FATHER

(State or country)

Harford Co. Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Hicks

13 BIRTHPLACE OF MOTHER

(State or Country)

Harford Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James L. Farrung

(Address)

Aberdeen Md.

15 Filed

Jan 7

1923

C. C. Michael

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 30

1923

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

June

1927

to

Dec 30, 1923

that I last saw him alive on Dec 30, 1923

and that death occurred on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH \* was as follows:

Old Bronchitis  
Mitral insufficiency - cardiac  
decompensation

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

Bronchopneumonia

(Duration)

yrs.

mos.

ds.

(Signed)

L. P. Thompson

M. D.

Dec 31, 1923

(Address)

Aberdeen Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grave Cemetery

Jan 2, 1924

20 UNDERTAKER

ADDRESS

Henry Farrington, Aberdeen



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Near Harford Grace (No. 3739) (Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Paul Emerson Reynolds

0520  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 155

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 10, 1896  
(Month) (Day) (Year)

7 AGE 33 yrs. 6 mos. 6 ds. or min. If LESS than 1 day hrs. min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Med. Phys.  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Balto City

10 NAME OF FATHER Rev. F. Ruphold

11 BIRTHPLACE OF FATHER (State or country) Balto City

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mc Catherine Reynolds

(Address) 3739 Roland Ave

15 Filed Jan. 26 1930 Chas. J. Foley M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 26<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 1<sup>45</sup> A.M.

The CAUSE OF DEATH \* was as follows:  
From Fracture at the base of skull  
Caused by accidentally running car  
into concrete buttress at Hunted Bridge,  
State Rd. Har. Co. (Duration) yrs. mos. ds.

Contributory  
Secondary (Duration) yrs. mos. ds.

(Signed) Martin P. Foley "Coroner" M. D.  
Jan. 26<sup>th</sup> 1930 (Address) Harford Grace Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3739 Roland Ave Balto Md

19 PLACE OF BURIAL OR REMOVAL Londan Park

DATE OF BURIAL Jan 28, 1930

20 UNDERTAKER R. S. Marshall ADDRESS 3539 Fall Road



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid housekeepers who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1930

BUREAU OF



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Bellair (No. \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 1822 FULL NAME George W. Richardson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

Oct 13, 1845  
(Month) (Day) (Year)

7 AGE

84 yrs. 4 mos. 30 ds. or min.?

If LESS than

1 day \_\_\_\_ hrs.

or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Varyes.

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Harford, Co. Md.

10 NAME OF FATHER

Henry Richardson

11 BIRTHPLACE OF FATHER

(State or country)

Harford, Co. Md.

12 MAIDEN NAME OF MOTHER

Elizabeth MacJee

13 BIRTHPLACE OF MOTHER

(State or country)

Harford, Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Nannie Richardson

(Address)

Bellair Md.

15

Filed

Mar 12, 1930 W. E. Richardson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 12, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1925 to Mar 12, 1930that I last saw him alive on Mar 11, 1930and that death occurred on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH \* was as follows:

Myocarditis  
Arteriosclerosis(Duration) 5 yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory  
SecondaryPulmonary edema

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

W. E. Richardson

M. D.

Mar 12, 1930

(Address)

Bellair Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Ignatius Cath. ChurchMarch 14, 1930

20 UNDERTAKER

ADDRESS

Hornbush & GrossBellair, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Teacher," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A like data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 5 1930

BUREAU



MARGIN RESERVED FOR RECORD  
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hartford

13861

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 181

Village or City Aberdeen (No. \_\_\_\_\_)

St.: \_\_\_\_\_ Ward: \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Thomas Richardson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH November 25<sup>th</sup>, 1857  
(Month) (Day) (Year)

7 AGE 73 yrs. - 5 mos. 5 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Shelby Co. Kentucky

10 NAME OF FATHER Mitchell Green Richardson

11 BIRTHPLACE OF FATHER (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Elisabeth Hastings

13 BIRTHPLACE OF MOTHER (State or Country) Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. S. Middleton  
(Address) 21 E. Pomfret St. Charles Pk

15 Filed Dec 2 1923 O. C. M. H. H.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 28 1930 to Nov 30, 1930

that I last saw her alive on Nov 30, 1930

and that death occurred on the date stated above, at 110 P m.

The CAUSE OF DEATH \* was as follows:

Intestinal Obstruction

(Duration) 0 yrs. 0 mos. 3 ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) O. C. M. H. H. M.D.  
See 1 1930 (Address) Aberdeen Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bakers Cemetery DATE OF BURIAL Dec 2, 1930

20 UNDERTAKER Henry J. J. J. J. ADDRESS Aberdeen Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer—retired 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the PRE-  
EASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diptheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a] questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

DEC 6 1930  
BUREAU 4.3.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Bellan Md (No. \_\_\_\_\_)

2 FULL NAME Allie Dextor Pierson

(87)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Sept 8, 1879  
(Month) (Day) (Year)

7 AGE 51 yrs. 3 mos. 9 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Houseduties  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Va

10 NAME OF FATHER Chas Hensley

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Maebey Berich

13 BIRTHPLACE OF MOTHER (State or Country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas E Pierson

(Address) Bellan Md

15 Filed Dec 19 1930 V. C. Chambers

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 15 1930 to Dec 17 1930

that I last saw him alive on Dec 17, 1930

and that death occurred on the date stated above, at 3:25 A. M.  
The CAUSE OF DEATH \* was as follows:

Angious Pectoris

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Chas Richardson M. D.  
Dec 18 1930 (Address) Bellan Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bakers Cemetery DATE OF BURIAL Dec 19, 1930

20 UNDERTAKER Dean Taylor ADDRESS Bellan Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Richardson



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931  
BUREAU V. S.



MARGIN RESERVED FOR RECORDING  
WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		COUNTY		WITHIN CORPORATE LIMITS OF		STATE OF MARYLAND		CERTIFICATE OF DEATH	
County <u>Harford</u>		Village or City <u>Hdelsrace</u> (No. _____)		St. _____ Ward _____		Registration Dist. No. <u>185</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Margaret Keely Rigdon</u>									
PERSONAL AND STATISTICAL PARTICULARS					MEDICAL CERTIFICATE OF DEATH				
3 SEX <u>Female</u>		4 COLOR OR RACE <u>white</u>		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>		16 DATE OF DEATH <u>Feb 13, 1930</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>Sept. 14, 1871</u> (Month) (Day) (Year)		7 AGE <u>58</u> yrs. <u>5</u> mos. <u>12</u> ds. or min.?		If LESS than 1 day ____ hrs.		17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb 1, 1930</u> to <u>Feb 13, 1930</u> that I last saw him alive on <u>Feb 13, 1930</u> and that death occurred on the date stated above, at <u>11:30 A.M.</u> The CAUSE OF DEATH * was as follows: <u>Arteriosclerosis</u> <u>Chronic Valvular Disease</u> <u>Acute Myocarditis</u> (Duration) <u>2</u> yrs. ____ mos. ____ ds.			
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)		<u>Housework</u>				Contributory Secondary <u>Coronary Failure</u> (Duration) ____ yrs. ____ mos. ____ ds.			
9 BIRTHPLACE (State or country)		<u>Maryland</u>				(Signed) <u>Charles J. Foley</u> M.D. <u>2/15, 1930</u> (Address) <u>High Street, Md.</u>			
10 NAME OF FATHER		<u>Charles B. Keely</u>				*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
11 BIRTHPLACE OF FATHER (State or country)		<u>Maryland</u>				18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents*) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.			
12 MAIDEN NAME OF MOTHER		<u>Alice Meeklin</u>				Where was disease contracted, if not at place of death? Former or usual residence _____			
13 BIRTHPLACE OF MOTHER (State or Country)		<u>Maryland</u>				19 PLACE OF BURIAL OR REMOVAL <u>Providence</u>		DATE OF BURIAL <u>Feb. 16, 1930</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Edward R. Rigdon</u> (Address) <u>Hdelsrace, Md.</u>					20 UNDERTAKER <u>Severington</u>		ADDRESS <u>Hdelsrace, Md.</u>		
15 Filed <u>Feb. 15, 1930</u> <u>Chas. J. Foley, M.D.</u> Registrar									



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Truemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1930  
BUREAU V. 5.



MARGIN RESERVED FOR BURIAL RECORD  
WRITE IN INK ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford13862  
(140)  
WITHIN CORPORATE LIMITS OFSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Edel Grace (No. \_\_\_\_\_)St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME James H. Robinson Jr.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widower  
(Write the word)6 DATE OF BIRTH March 17, 1\_\_\_\_\_,  
(Month) (Day) (Year)7 AGE 74 yrs. 8 mos. 3 ds. or \_\_\_\_\_  
If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work liveryman  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE  
(State or country) Maryland10 NAME OF FATHER William Robinson11 BIRTHPLACE OF FATHER  
(State or country) Maryland12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER  
(State or Country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Robinson Jr.(Address) Edel Grace, Md.15 Filed Nov. 22 1930 by J. Foley, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 21, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from June 1, 1929, to Nov 20, 1930,  
that I last saw him alive on Nov 20, 1930,  
and that death occurred on the date stated above, at 3 a. m.

The CAUSE OF DEATH \* was as follows:

Barbara C. Hemminger  
uræmiaContributory Secondary Arterio sclerosis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) J. L. Thompson M. D.  
Nov 26 1930 (Address) Harford, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Still Pond Cemetery, Nov. 21, 1930.

20 UNDERTAKER

ADDRESS

Pennington & Son Edel Grace, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1913



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

09340  
(90) STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 183

Village or City Shawonschen White Hall P.O. Ind. (No.     ) St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sarah Emma Robinson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6 DATE OF BIRTH July 16, 1854  
(Month) (Day) (Year)

7 AGE 78 yrs. 0 mos. 24 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer) At Home

9 BIRTHPLACE (State or country) Harford Co. Ind.

10 NAME OF FATHER Joseph Robinson

11 BIRTHPLACE OF FATHER (State or country) Harford Co. Ind.

12 MAIDEN NAME OF MOTHER Eliza Howell

13 BIRTHPLACE OF MOTHER (State or Country) Harford Co. Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos. M. S. Phillips  
(Address) White Hall Ind.

15 Filed Aug 16 1930 Thomas R. Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug. 11, 1930 to Aug. 14, 1930, that I last saw her alive on Aug. 14, 1930, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH \* was as follows:

Arterio-Sclerosis, Chronic Myocarditis

(Duration) 5 yrs.      mos.      ds.  
Contributory Secondary Cerebral Hemorrhage

(Signed) Chas. C. Ayres M.D.  
Aug 15, 1930 (Address) White Hall Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethel DATE OF BURIAL Aug 16, 1930

20 UNDERTAKER P. Macklinson ADDRESS White Hall Ind.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Harford

12895

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

182

Village or City

Bel Air Md. (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Thomas H. Robinson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

Mar 2, 1860  
(Month) (Day) (Year)

7 AGE

70 yrs. 8 mos. 10 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Sam'l Robinson

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Pragg

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Celara Cain Robinson

(Address)

Bel Air Md

15 Filed

Oct 14 1930 J. E. Richardson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 12, 1930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1925 to Oct 12, 1930

that I last saw him alive on Oct 12, 1930

and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH \* was as follows:

(Coronary Occlusion)  
(Angina Pectoris)

(Duration) yrs. 2 mos. ds.

Contributory  
Secondary

Hypertension

(Duration) 37 yrs. mos. ds.

(Signed)

Dr. H. H. H. H. H.

M. D.

Oct 14 1930 (Address) Bel Air Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Signatures

Oct 15, 1930

20 UNDERTAKER

ADDRESS

Dean &amp; Foster

Bel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

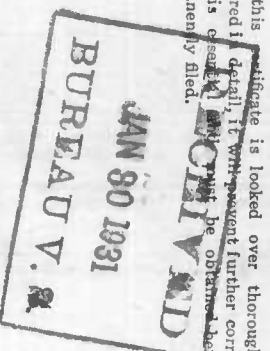
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





MARGIN RESERVED FOR RECORDING  
WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			12845		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford Co</u>			(129)		Registration Dist. No. <u>182</u>	
Village or City <u>Forest Hill</u> (No. _____)			St. _____		Ward _____	
2 FULL NAME <u>Annetta Rogers</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)				
6 DATE OF BIRTH <u>May 7, 1882</u> (Month) (Day) (Year)						
7 AGE <u>48</u> yrs. <u>5</u> mos. <u>8</u> ds. or _____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House duties</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>md</u>						
10 NAME OF FATHER <u>Frank Grafton</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>md</u>						
12 MAIDEN NAME OF MOTHER <u>Levin Thamar</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>md</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. M. J. Rogers</u> (Address) <u>Forest Hill</u>						
15 Filed <u>Oct. 17 1930</u> <u>O. E. Chambers</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Oct 15, 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Oct 13, 1930</u> to <u>Oct 15, 1930</u> , that I last saw her alive on <u>Oct 14, 1930</u> , and that death occurred on the date stated above, at <u>9 A</u> m. The CAUSE OF DEATH * was as follows:						
<u>Cerebral Hemorrhage (with left sided hemiplegia)</u> (Duration) _____ yrs. _____ mos. <u>7 1/2</u> ds.						
Contributory <u>Ch. Glomerular Nephritis</u> Secondary (Duration) <u>4</u> yrs. _____ mos. _____ ds.						
(Signed) <u>Willard B. Hedgson</u> M. D. <u>Oct 15, 1930</u> (Address) <u>Forest Hill, Md</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.						
Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Center M.E.</u>					DATE OF BURIAL <u>Oct 17, 1930</u>	
20 UNDERTAKER <u>Dean &amp; Foster</u>					ADDRESS <u>Bel Air Md</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

130



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter; Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinster*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deputy," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Leban pneumonia*, *Bronchopneumonia* ("Pneumonia";

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BUREAU OF

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by running train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hyford

Village or City Edgewood (No. ....)

2 FULL NAME Daisy Rogers

06776

(74a)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 180

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH July 26, 1891  
(Month) (Day) (Year)

7 AGE 38 yrs. 10 mos. 22 ds. If LESS than 1 day... hrs. or... min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Washington D.C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edwin Harris

(Address) Edgewood

15 Filed June 19 1923 Fred H. Baylark Registrar  
local

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 18, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1929 192... to June 18, 1923

that I last saw him alive on June 17, 1923

and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH \* was as follows:

Cerebral hemorrhage  
(Duration) 4 yrs. 4 mos. 4 ds.

Contributory  
Secondary

(Signed) Charles R. Potts M. D.  
June 18, 1923 (Address) Edgewood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Abingdon Cemetery June 20, 1923

20 UNDERTAKER

ADDRESS

Howard K. McElman Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Icteric," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County HartfordVillage or City Pryman (No. \_\_\_\_\_)2 FULL NAME James H. Riggins

04397

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
(Write the word)

6 DATE OF BIRTH April 17, 1858  
(Month) (Day) (Year)

7 AGE 77 yrs. 0 mos. 10 ds. or min. LESS than 1 day \_\_\_\_\_ hrs.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country)10 NAME OF FATHER John Riggins11 BIRTHPLACE OF FATHER  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Rachel Nizer13 BIRTHPLACE OF MOTHER  
(State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Douglas, Mrs. F. Robinson(Address) Pryman

15 Filed April 29, 1930 Fred. Morlock  
local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr. 1927 to Apr. 27, 1930, that I last saw him alive on April 27, 1930, and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH \* was as follows:

Diabetes and  
Carcinoma of leg. c. v. s. R.  
(Duration) 3 yrs. 10 ds.

Contributory  
Secondary

(Signed) Dothier (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
April 27, 1930 (Address) Pryman Md M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence Magnolia Md.

## 19 PLACE OF BURIAL OR REMOVAL

Ebenezer Cemetery

## DATE OF BURIAL

April 30, 1930

## 20 UNDERTAKER

Howard K. McComas,

## ADDRESS

Abingdon?, Md.



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(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysentery* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 3 1930

BUREAU V. S.



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1 PLACE OF DEATH  
County Harford

WITHIN CORPORATE LIMITS OF  
Exton (112)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Hdelsrace, (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Phoebe F. Rouse

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6 DATE OF BIRTH April 18 - 1884  
(Month) (Day) (Year)

7 AGE 88 yrs. 10 mos. 19 ds. or min.? If LESS than 1 day .... hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Housework (b) General nature of industry business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John D. Walker

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Bartol

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Rouse  
(Address) Hdelsrace, Md.

15 Filed March 11 1930 Chas. J. Foley, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 10, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 9, 1930 to March 10, 1930.

that I last saw him alive on March 9, 1930.

and that death occurred on the date stated above, at 3 a m.

The CAUSE OF DEATH \* was as follows:

Acute Gastritis

(Duration) .... yrs. .... mos. .... ds.  
Contributory Secondaries Cerebral Failure  
Shock

(Signed) F. W. Steiner M. D.  
3-11-1930 (Address) Harford, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Angel Bleecker DATE OF BURIAL March 12 1930

20 UNDERTAKER Remington ADDRESS Hdelsrace



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

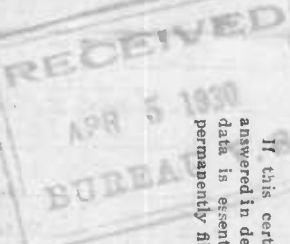
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Nanny, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecoses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a question answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hayward

Village or City Joppla (No. \_\_\_\_\_)

2 FULL NAME Anita Ruff

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Mar 10, 1930  
(Month) (Day) (Year)

7 AGE 4 yrs. 28 mos. 28 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER David Ruff

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER May P. Henson

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David Ruff

(Address) Joppla

15 Filed Aug 9 1930 NE Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_, 192\_\_\_\_ to \_\_\_\_\_, 192\_\_\_\_

that I last saw him alive on \_\_\_\_\_, 192\_\_\_\_

and that death occurred on the date stated above, at 90 m.

The CAUSE OF DEATH \* was as follows:

Immature Birth - 7-mo

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Charles Ruff M. D.

Aug 8, 1930 (Address) Edge wood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Tabernacle of Cen Aug 9, 1930

20 UNDERTAKER ADDRESS

Hamberson & Sons Benson Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Corcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



- MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford County

04398 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

Village or City Greenville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Harvey Russell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH October, 1874.  
(Month) (Day) (Year)

7 AGE 55 yrs. 7 mos.  ds. or  min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Harford County

10 NAME OF FATHER Martin Russell

11 BIRTHPLACE OF FATHER (State or country) md.

12 MAIDEN NAME OF MOTHER Keener

13 BIRTHPLACE OF MOTHER (State or Country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Lillian Knight  
(Address) 734 E. 36th St.

15 Filed May 1 1930 Fred Aborlak Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 27, 1930.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from " 192 to " 192, that I last saw him alive on \_\_\_\_\_, 192, and that death occurred on the date stated above, at 9-P. m. The CAUSE OF DEATH \* was as follows:

Unknown "Chronic Disease"  
Found Dead  
Heart trouble several months (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
C. & B.

Contributory Secondary \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Fred Aborlak Coroner M. D. April 30, 1930 (Address) Abingdon, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Abingdon County DATE OF BURIAL May 1, 1930

20 UNDERTAKER Howard K McNamee ADDRESS Abingdon Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 3 1930  
BUREAU



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1 PLACE OF DEATH  
County Harford WITHIN CORPORATE LIMITS OF

05644 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Harred Grove (No. 553 Green St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John A. Russell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Oct 2, 1848  
(Month) (Day) (Year)

7 AGE 81 yrs. 7 mos. 29 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired Coal Mkr.  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland  
10 NAME OF FATHER Samuel Russell

11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Elizabeth Williams  
13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Russell  
(Address) Harred Grove

15 Filed June 2 1930 Charles J. Foley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 31st, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from May 20th 1920 to May 31st 1930  
that I last saw him alive on May 31st, 1930,

and that death occurred on the date stated above, at 2 a m.  
The CAUSE OF DEATH \* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 7 ds.  
Contributory Secondary Influenza

(Duration) yrs. mos. 3 ds.  
(Signed) James H. Bay M. D.  
June 2nd 1920 (Address) Harred Grove Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Angel Hill Cemetery DATE OF BURIAL June 3, 1930

20 UNDERTAKER Pennington Dr ADDRESS Harred Grove



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For-man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 5 1930  
BUREAU V. B.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Harford

0521

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

184

Village or City

Mill Green (No. -)

St. - Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Alice Rutledge

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 SINGLE,

MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Aug. 31, 1857

(Month) (Day) (Year)

7 AGE

72 yrs. 4 mos. 6 ds. or min.?

IF LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Md.

10 NAME OF  
FATHER

Thomas Rutledge

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md.

12 MAIDEN NAME  
OF MOTHER

Cynthia Richardson

13 BIRTHPLACE  
OF MOTHER  
(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Gertrude R. Gardner

(Address)

Baltimore, Md. R.F.D.

15

Filed

Jan. 6, 1930. M. W. Rich.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 6, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Jan 10, 1929 to Jan 5, 1930

that I last saw her alive on Jan 5, 1930,

and that death occurred on the date stated above, at 3.9 m.

The CAUSE OF DEATH \* was follows:

Polar Pneumonia

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Charles W. Morgan M. D.

Jan 6, 1930 (Address) 1300 B. St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Highland Cem Jan 8, 1930

20 UNDERTAKER

ADDRESS

H. S. Bailey, Arlington, Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto. Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Méasles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, Tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 5 1920

BUREAU OF



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1 PLACE OF DEATH			13863		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			(66)		Registration Dist. No. <u>185</u>	
Village or City <u>Harre de Grace</u> (No. _____)			St. _____		Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>James J. Salib</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>				
6 DATE OF BIRTH <u>June 7, 1868</u> (Month) (Day) (Year)						
7 AGE <u>62</u> yrs. <u>5</u> mos. <u>10</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Maryland</u>						
10 NAME OF FATHER <u>John C. Salib</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>						
12 MAIDEN NAME OF MOTHER <u>L. Ann Salib</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. John C. Salib</u> (Address) <u>Harre de Grace Md.</u>						
15 Filed <u>Nov. 29, 1930</u> by <u>Chas. J. Foley</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Nov 27, 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov 26, 1930</u> to <u>Nov 27, 1930</u> that I last saw him alive on <u>Nov 27, 1930</u> and that death occurred on the date stated above, at <u>8:30</u> a.m. The CAUSE OF DEATH * was as follows: <u>Acute Alcoholism</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory Secondary <u>Cancer Falun</u> (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Charles J. Foley</u> M. D. <u>11/29, 1930</u> (Address) <u>Harre de Grace Md.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Angel Hill Rd</u>				DATE OF BURIAL <u>Nov 30, 1930</u>		
20 UNDERTAKER <u>P. Madison Mitchell</u>				ADDRESS <u>N. de G.</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

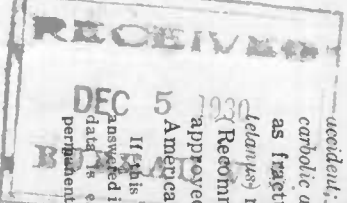
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (c) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR RECORD  
 ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			Registration Dist. No. <u>181</u>	
Village or City <u>Aberdeen Md.</u>			St. _____	Ward) _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Basil P. Sanner</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>January 17, 1843</u> (Month) (Day) (Year)				
7 AGE <u>86</u> yrs. <u>11</u> mos. <u>19</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired farmer</u> (b) General nature of industry business, or establishment in which employed (or employee) <u>for 12 yrs</u>				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
PARENTS	10 NAME OF FATHER <u>Capit. Isaac S. Sanner</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
	12 MAIDEN NAME OF MOTHER <u>Mary E. Blakee</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Mary E. Sanner</u> (Address) <u>Aberdeen Md.</u>				
15 Filed <u>Jan 7 1930</u> <u>O. L. Meekins</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Jan. 6, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 2 1930</u> to <u>Jan 5 1930</u> , that I last saw him alive on <u>12-19-29</u> , and that death occurred on the date stated above, at <u>12:19 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Cerebral Hemorrhage</u> (Duration) <u>0</u> yrs. <u>0</u> mos. <u>5</u> ds. Contributory <u>Paralysis</u> Secondary (Duration) <u>0</u> yrs. <u>0</u> mos. <u>5</u> ds. (Signed) <u>Wesley H. White</u> M. D. <u>Jan 7 1930</u> (Address) <u>Aberdeen, Md.</u> *State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Balcer Cemetery</u>			DATE OF BURIAL <u>Jan. 8, 1930</u>	
20 UNDERTAKER <u>Wm. Tarrington Sons</u>			ADDRESS <u>Aberdeen Md.</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Labar pneumonia, Bronchopneumonia* ("Pneumonia,"

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RECEIVED  
FEB 6 1930  
BUREAU



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## 1 PLACE OF DEATH

County

Stanford

Village or City

Stuart (No. \_\_\_\_\_)

St.: Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Nelson Scarborough

09342 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

November 13, 1882  
(Month) (Day) (Year)

7 AGE

33 yrs. 8 mos. 26 ds. or min.?

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired Farmer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Md

10 NAME OF  
FATHER

John Scarborough

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md

12 MAIDEN NAME  
OF MOTHER

Julia Howlett

13 BIRTHPLACE  
OF MOTHER  
(State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nellie Scarborough,

(Address)

11 Street, Md.

15

Filed

Aug. 10 1923 D. J. McCabe

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 9, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Aug 4, 1923 to Aug 8, 1923  
that I last saw him alive on Aug 8, 1923,

and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH \* was as follows:

Cerebral Haemorrhage

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 5 ds.

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Charles H. Hays, M. D.

1923 (Address) Street B. Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cemetery, Md Aug 12, 1923

20 UNDERTAKER

ADDRESS

J. H. Hoff, East Lane Pa

If more banks are needed, address State Registrar, 16 N. Saratoga St., Balt., requesting V. S. No. 1.



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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Harford

13864

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 190Village or City Joppa (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Schlereth

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write this word) <u>married</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH <u>June 18, 1863</u> (Month) (Day) (Year)
---

7 AGE <u>67 yrs. 5 mos. 9 ds.</u>	If LESS than 1 day ____ hrs. or ____ min.?
--------------------------------------	--

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer)
--

9 BIRTHPLACE (State or country) <u>Maryland</u>
---

10 NAME OF FATHER <u>Michael Schlereth</u>
---

11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>
---

12 MAIDEN NAME OF MOTHER <u>Anna Whitman</u>
---

13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>
---

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary L. Schlereth(Address) Joppa, Md.

15 Filed <u>November 29, 1930</u> <u>Fred Morlok</u> <u>Registrar</u>
---

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>Nov. 29, 1930</u> (Month) (Day) (Year)
--

17 I HEREBY CERTIFY, That I attended the deceased from <u>1924</u> to <u>Nov 29, 1930</u>
--

that I last saw him alive on Nov 26, 1930and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH \* was as follows:

Chronic Nephritis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) <u>Chas. Richardson</u> <u>Nov. 29, 1930</u> (Address) <u>Baltimore</u>	M. D.
---	-------

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.	In the State ____ yrs. ____ mos. ____ ds.
--	---

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL <u>St Stephens County</u>	DATE OF BURIAL <u>Nov 29, 1930</u>
--	---------------------------------------

20 UNDERTAKER <u>Howard K McCombs</u>	ADDRESS <u>Abingdon</u>
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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia," *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 3 1900  
BUREAU V. B.



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

10489

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 181Village or City Eberdeen (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John R. Scott

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH April 15, 1900  
(Month) (Day) (Year)

7 AGE 30 yrs. 4 mos. 18 ds. IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work Fireman(b) General nature of industry business, or establishment in which employed or (employer) B & O R.R.9 BIRTHPLACE  
(State or country)Baltimore

## 10 NAME OF FATHER

Geo. E. Scott

## 11 BIRTHPLACE OF FATHER

MD

## 12 MAIDEN NAME OF MOTHER

Clara Blunt

## 13 BIRTHPLACE OF MOTHER

MD

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mildred R. Scott(Address) 576 E. 41st St.15 Filed Sept 4 1920Michael

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 8, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

192 to 192  
that I last saw him alive on 7 192  
after struck, was then dead  
and that death occurred on the date stated above, at \_\_\_\_\_, MD.

The CAUSE OF DEATH \* was as follows:

Accidently struck by  
B & O R.R. train, fractured  
skull & legs -  
death occurred immediately  
B & O Station in Baltimore (Duration) ys. 0 mos. 0 ds.

Contributory  
Secondary

(Signed) Christie (Duration) ys. 0 mos. 0 ds.  
Sept 4 1920 (Address) Eberdeen MD

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Parsonage Cemetery Sept 6 1920  
Baltimore MD

## 20 UNDERTAKER

## ADDRESS

Kentham & Co 1723 W. Lofgren



*Inf. in red ink secured from person who obtained a certified copy.*

## REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

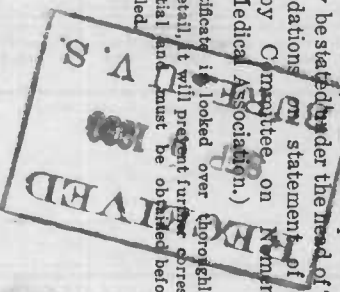
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





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1 PLACE OF DEATH		WITHIN CORPORATE LIMITS OF		0523 STATE OF MARYLAND	
County <u>Harford</u>		(128)		CERTIFICATE OF DEATH	
Village or City <u>Harre de Grace</u>		St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Caroline Shaffer</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>August 25, 1869</u> (Month) (Day) (Year)					
7 AGE <u>60</u> yrs. <u>5</u> mos. <u>2</u> ds. or min. If LESS than 1 day ____ hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
10 NAME OF FATHER <u>William Morgan</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>					
12 MAIDEN NAME OF MOTHER <u>Unknown</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Howard Grumb</u> (Address) <u>Heelrace, Md.</u>					
15 Filed <u>1/30</u> 19 <u>30</u> <u>Charles J. Foley</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan 28, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 6, 1930</u> to <u>Jan 28, 1930</u> , that I last saw her alive on <u>Jan 28, 1930</u> , and that death occurred on the date stated above, at <u>5:45 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Acute Myocarditis</u> <u>Acute Nephritis</u> (Duration) ____ yrs. ____ mos. <u>22</u> ds. Contributory <u>Cardiac &amp; Respiratory failure</u> Secondary (Duration) ____ yrs. ____ mos. <u>13</u> ds. (Signed) <u>Charles J. Foley</u> M. D. <u>1/30</u> 19 <u>30</u> (Address) <u>Shoremonte, Md.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Angel Hill Cemetery</u>				DATE OF BURIAL <u>1/30, 1930</u>	
20 UNDERTAKER <u>Pennington &amp; Sons</u>				ADDRESS <u>Heelrace, Md.</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; a void use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1930

BUR



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Anne Arundel

Village or City Aldino (No. ....) St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME No name

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 181

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Unknown 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH July 14 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min. If LESS than 1 day, 0 hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) -

9 BIRTHPLACE (State or country) Aldino

10 NAME OF FATHER Harry H. Shaffer  
11 BIRTHPLACE OF FATHER MD  
12 MAIDEN NAME OF MOTHER Helen G. Parker  
13 BIRTHPLACE OF MOTHER MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry H. Shaffer  
(Address) Aldino RD 9 MD

15 Filed July 14 1930 Registrar Of Michael

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 14 1930 to July 14 1930  
that I last saw him alive on July 14 1930

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH was as follows:  
3 mos - Premature

Still born  
(Duration) .... yrs. .... mos. .... ds.

Contributory Secondary

(Signed) Thos. H. Shaffer M.D.  
July 14 1930 (Address) Aldino MD

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

A: place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL In garden at home DATE OF BURIAL July 14 1930

20 UNDERTAKER Ketter ADDRESS Aldino MD



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic nodular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County HanfordVillage or City near Bel Air (No. \_\_\_\_\_)01742 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 182

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Howard Sharpe

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)6 DATE OF BIRTH Unknown 1921  
(Month) (Day) (Year)7 AGE 28 yrs. Unknown mos. Unknown ds. or min. (If LESS than 1 day \_\_\_\_ hrs.)8 OCCUPATION  
(a) Trade, profession or particular kind of work Sailor  
(b) General nature of industry, business, or establishment in which employed or (employer) U. S. Navy9 BIRTHPLACE (State or country) Unknown10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Shep. Deacy Bowman(Address) Bel Air Md15 Filed Feb 17 1930 N. E. Richardson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 15 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192that I last saw him alive on 192and that death occurred on the date stated above, at about 9:30 p.m.

The CAUSE OF DEATH \* was as follows:

Accidental Automobile

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Chas. Richardson M. D.Feb 17 1930 (Address) Bel Air Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington D.C. Feb 18 1930

20 UNDERTAKER ADDRESS

Deacy Foster Bel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

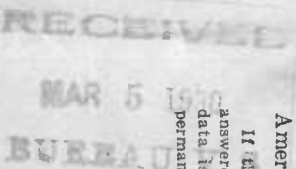
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. (FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory.") (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.







WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Harford

12846

113

WITHIN CORPORATE LIMITS U.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Harwick (No. 1)

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Elmer C Shutt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Dec 27 1929  
(Month) (Day) (Year)

7 AGE 9 yrs. 29 mos. 29 da. or 29 min. ?  
If LESS than 1 day.... hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) None

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Paul K Shutt

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Hannah Brinkman

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul K Shutt

(Address) Harwick

15 Filed Oct. 26 1930 Charles J. Foley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 26 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 1 1930 to Oct 25 1930 that I last saw him alive on Oct 25 1930 and that death occurred on the date stated above, at 7:41 a.m.

The CAUSE OF DEATH was as follows:  
His Colitis

(Duration) 9 yrs. 29 mos. 29 da.  
Contributory Impure Diet - Exhaustion  
Secondary

(Signed) Charles J. Foley M. D.  
Oct. 26 1930 (Address) Harwick

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 9 yrs. 29 mos. 29 da. In the State, 9 yrs. 29 mos. 29 da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Wesleyan Chapel Co DATE OF BURIAL Oct 27 1930

20 UNDERTAKER H S Bailey ADDRESS Wilmington Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.** Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.** Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia*, "Pneumonia."

"unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (R commendations on state-ment of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1930

BUREAU OF VITAL STATISTICS







# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

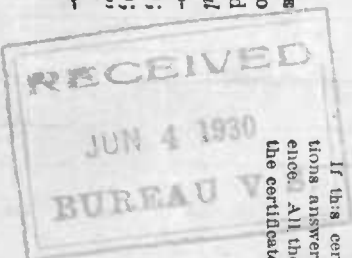
*See note for Dr. Callahan re. gender of person - 4/1931*

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"); *unqualified*. is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *ACCIDENTAL*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Ran over wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR FILING  
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH			05646		STATE OF MARYLAND	
County <u>Baltimore</u> WITHIN CORPORATE LIMITS OF			(129)		CERTIFICATE OF DEATH	
Village or City <u>Hamlet de Grace</u> (No. _____)			Registration Dist. No. <u>185</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John T Skinner</u>			St. _____		Ward _____	
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)				
6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year)						
7 AGE <u>abt. 63</u> yrs. - mos. - ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Labor</u> (b) General nature of industry, business, or establishment in which employed or (employer)						
9 BIRTHPLACE (State or country) <u>Maryland</u>						
PARENTS	10 NAME OF FATHER <u>Jacob Skinner</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>					
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>Henry Skinner</u>						
(Address) <u>Hamlet de Grace Md</u>						
15 Filed <u>May 21 1930</u> <u>Chas. J. Foley, M.D.</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>May 20, 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>May 1, 1930</u> to <u>May 20, 1930</u> , that I last saw him alive on <u>May 20, 1930</u> , and that death occurred on the date stated above, at <u>6.9</u> m. The CAUSE OF DEATH * was as follows:						
<u>Acute Regurgitation</u> <u>Chronic Rheumatism</u> (Duration) yrs. mos. ds. <u>Cardiac Failure</u> Contributory Secondary (Duration) yrs. mos. ds. (Signed) <u>Chas. J. Foley, M.D.</u> <u>5/21 1930</u> (Address) <u>Hamlet de Grace Md</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)						
At place of death yrs. mos. ds. In the State yrs. mos. ds.						
Where was disease contracted, if not at place of death?						
Former or usual residence						
19 PLACE OF BURIAL OR REMOVAL <u>Skinner Cemetery</u>						DATE OF BURIAL <u>May 23, 1930</u>
20 UNDERTAKER <u>Remington Don</u>						ADDRESS <u>Hamlet de Grace</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUN 5 1930  
BUREAU



MARGIN RESERVED FOR EMBELLISHING  
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u>		10430 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Bel Air</u> (No. <u>181</u> )		Registration Dist. No. <u>181</u>	
2 FULL NAME <u>Carrie Smith</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	
6 DATE OF BIRTH <u>Jan</u> <u>15</u> , 18 <u>74</u> (Month) (Day) (Year)			
7 AGE <u>56</u> yrs. <u>8</u> mos. <u>10</u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House worker</u> (b) General nature of industry, business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>George W. Croger</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Rebecca Hooper</u>		
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Helen C. Calks</u> (Address) <u>Bel Air R.F.D. #1</u>			
15 Filed <u>Sept 27</u> 19 <u>30</u>	16 DATE OF DEATH <u>September</u> <u>26</u> , 19 <u>30</u> (Month) (Day) (Year)		
17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 21</u> 19 <u>30</u> to <u>Sept 23</u> 19 <u>30</u> , that I last saw him alive on <u>Sept 23</u> 19 <u>30</u> , and that death occurred on the date stated above, at <u>2:00 P.M.</u> The CAUSE OF DEATH * was as follows: <u>Arterio Sclerosis</u> <u>Hypertension</u> (Duration) <u>1</u> yrs. <u>4</u> mos. <u>4</u> ds. Contributory Secondary <u>Cardiac Failure</u> (Duration) <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds. (Signed) <u>Charles J. Foley</u> M. D. <u>Sept 27 1930</u> (Address) <u>Harford, Md.</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>1</u> yrs. <u>4</u> mos. <u>4</u> ds. In the State <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds. Where was disease contracted, if not at place of death? Former or usual residence		19 PLACE OF BURIAL OR REMOVAL <u>Asbury Cemetery</u> DATE OF BURIAL <u>Sept. 28, 1930.</u>	
20 UNDERTAKER <u>Henry Tanning Sons</u>		ADDRESS <u>Chesapeake Md.</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

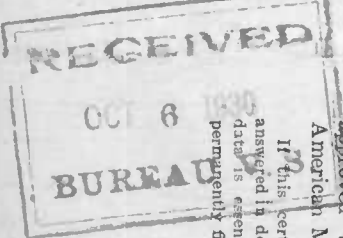
(Approved by U. S. Census and American Public  
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**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed





WRITE

WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County HarfordVillage or City Rocks

(No. \_\_\_\_\_)

13865 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 183

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Harold Glenn Smithson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH

Jan. 19 1880  
(Month) (Day) (Year)

7 AGE

51 yrs. 10 mos. 10 ds. or min. ?  
If LESS than 1 day....hrs.

## OCCUPATION

(a) Trade, profession or particular kind of work Sign Painter

(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE

(State or country)

Harford Co.

10 NAME OF FATHER

James T. Smithson

11 BIRTHPLACE OF FATHER

(State or country)

Harford Co. Md.

12 MAIDEN NAME OF MOTHER

Orpha Ann Glenn

13 BIRTHPLACE OF MOTHER

(State or country)

Harford C. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillian L. Smithson

(Address)

Rocks Md.

15

Filed Nov 30 1930 Thomas R. Brown  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 29 29 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Aug 3 1930 to Nov 26 1930  
that I last saw him alive on Nov 26 1930,  
and that death occurred on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH was as follows:

Sarcoma of IntestinesContributory  
Secondary(Duration) 4 yrs. — mos. — da.(Duration) — yrs. — mos. — da.(Signed) H. H. Bradley M.D.Nov 30 1930 (Address) Camettsville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — da.In the State, — yrs. — mos. — da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel Cem.Dec. 1, 1930

20 UNDERTAKER

ADDRESS

E. G. Kurtz & SonJarrettsville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

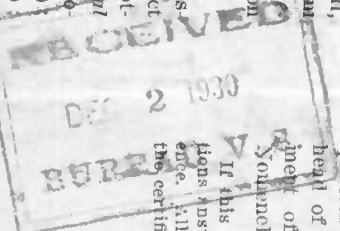
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmers (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Con-vulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misadventure as "PERIPARTAL septicæmia," "PERIPARTAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





08093

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 182

1 PLACE OF DEATH

County HarfordVillage or City Bagley (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME unnamed Smithers

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Infant6 DATE OF BIRTH July 24 1930  
(Month) (Day) (Year)7 AGE ..... If LESS than 1 day..... hrs. .... yrs. .... mos. 1 ds. or min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed or (employer) .....9 BIRTHPLACE (State or country) Md.10 NAME OF FATHER Chas. Smithers11 BIRTHPLACE OF FATHER (State or country) Harford Co.12 MAIDEN NAME OF MOTHER Mary Banks13 BIRTHPLACE OF MOTHER (State or country) Harford Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Smithers  
(Address) Bel Air, Md.15 Filed July 25 1930 N.E. Richardson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 24 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 24 1930 to July 26 1930  
that I last saw her alive on July 24 1930  
and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH \* was as follows:

Unknown  
Probably impairment of circulation.  
(Duration) 2 hrs. yrs. .... mos. 1 ds.Contributory  
Secondary(Duration) yrs. .... mos. .... ds.  
(Signed) F. Lee Hughes M.D.  
July 25 1930 (Address) Bel Air, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, -X  
if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Clarke Chap-Cem DATE OF BURIAL July 26 193020 UNDERTAKER The Farther ADDRESS Bagley

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BEING

WRITE HERE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Coremia, Sarcema, etc.* . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *23 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1930

BUREAU



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## 1 PLACE OF DEATH

County Hampden Co.

15079

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Hampden (No. Hampden Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME John Spearman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) ✓6 DATE OF BIRTH Dec. 5, 1896  
(Month) (Day) (Year)7 AGE 34 yrs. 11 mos. 28 ds. or min. IF LESS than 1 day \_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Chef  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) North Carolina10 NAME OF FATHER Marshall Spearman11 BIRTHPLACE OF FATHER (State or country) North Carolina12 MAIDEN NAME OF MOTHER Rosie Spearman13 BIRTHPLACE OF MOTHER (State or Country) North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. A. Elliott(Address) 1725 Ashland Ave15 Filed Dec. 25, 1930 Chas. J. Foley, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 25, 1930  
12 (Month) 25 (Day) (Year) 193017 I HEREBY CERTIFY, That I attended the deceased from Dec. 22, 1930 to Dec. 25, 1930;that I last saw him alive on Dec. 24, 1930;and that death occurred on the date stated above, at 6 a. m.  
The CAUSE OF DEATH \* was as follows:Diabetes Mellitus  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory  
Secondary(Signed) J. H. Steiner M. D.  
12-25-1930 (Address) Hampden

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Put Calvary DATE OF BURIAL Dec 28, 193020 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Ashland Ave  
Balto. Ind.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 3 1922  
BUREAU OF VITAL STATISTICS



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH		WITHIN CORPORATE LIMITS OF 03043		STATE OF MARYLAND	
County <u>Hanford</u>		(90)		CERTIFICATE OF DEATH	
Village or City <u>Harve de Grace Hospital</u>		St. _____		Registration Dist. No. <u>185</u>	
2 FULL NAME <u>Charles Spencer</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)			
6 DATE OF BIRTH <u>March 15, 1865</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>March 29, 1930</u> (Month) (Day) (Year)			
7 AGE <u>65 yrs. — mos. 14 ds. or min.</u> If LESS than 1 day hrs.		17 I HEREBY CERTIFY, That I attended the deceased from <u>Mar 1, 1920</u> to <u>Mar 29, 1930</u> that I last saw him alive on <u>Mar 29, 1930</u> and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Senility - Cardiac</u> <u>Recompensation</u> (Duration) _____ yrs. _____ mos. _____ ds.			
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)		Contributory Secondary			
9 BIRTHPLACE (State or country)		(Duration) _____ yrs. _____ mos. _____ ds.			
10 NAME OF FATHER		(Signed) _____ M. D.			
11 BIRTHPLACE OF FATHER (State or country)		4-1-30 192 (Address) <u>Harve de Grace Md</u>			
12 MAIDEN NAME OF MOTHER		*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
13 BIRTHPLACE OF MOTHER (State or Country)		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Daniel Webster</u> (Address) <u>Aberdeen, Md.</u>		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
15 Filed <u>Apr 1, 1930</u> <u>James J. Taylor</u> Registrar		Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
		19 PLACE OF BURIAL OR REMOVAL <u>Union M.E. Cemetery</u>		DATE OF BURIAL <u>April 3, 1930</u>	
		20 UNDERTAKER <u>Wm. Tarrington &amp; Sons</u>		ADDRESS <u>Aberdeen, Md</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Coreinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
APR 9 1930  
BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Starford

WITHIN CORPORATE LIMITS OF

1284

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 185Village or City Starrett's Grace No. 784

St. \_\_\_\_\_ Ward \_\_\_\_\_

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME J. Herman Spencer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widower  
(Write the word)6 DATE OF BIRTH Feb. 25, 1846  
(Month) (Day) (Year)7 AGE 84 yrs. 8 mos. 0 ds. or 0 min. ?  
If LESS than 1 day... hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed or (employer) Farmer9 BIRTHPLACE (State or country) Md.

PARENTS	10 NAME OF FATHER <u>Garrett Spencer</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Herbert</u>
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Hughes Spencer  
(Address) Starrett's Grace15 Filed Oct. 26, 1920 Charles J. Kelly Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 25, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Oct. 5, 1920, to Oct. 25, 1920, that I last saw him alive on Oct. 24, 1920, and that death occurred on the date stated above, at 29 m.

The CAUSE OF DEATH was as follows:

Fracture of neck of  
left femur (due to fall)  
(Duration) ... yrs. ... mos. ... da.Contributory Cardiac dilatation  
Secondary  
(Duration) ... yrs. ... mos. ... da.(Signed) J. H. Spencer M. D.  
Oct. 26, 1920 (Address) Starrett's Grace, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... da. In the State, ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rock Run Cem. DATE OF BURIAL Oct. 27, 192020 UNDERTAKER A. S. Bailey Address Warlington



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on, may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia").

Unqualified, is indefinite); *Tuberculosis of lungs*, men-  
ingitis peritonaei, etc. *Carcinoma*, *Sarcoma*, etc., of  
... (name origin; "Cancer" is less definite; avoid  
use of "Tumor" for malignant neoplasms); *Measles*;  
*Whooping cough*; *Chronic valvular heart disease*;  
*Chronic interstitial nephritis*, etc. The contributory  
(secondary or intercurrent) affection need not be  
stated unless important. Example: *Measles* (disease  
causing death), 29 ds.; *Bronchopneumonia* (second-  
ary), 10 ds. Never report mere symptoms of terminal  
conditions, such as "Aschemia," "Anæmia" (merely  
symptomatic), "Atrophy," "Collapse," "Coma," "Con-  
vulsions," "Debility" ("Congenital," "Senile," etc.),  
"Dropsy," "Exhaustion," "Heart failure," "Hæmor-  
rhage," "Mania," "Mammas," "Old Age," "Shock,"  
"Træmia," "Weakness," etc., when a definite disease  
can be ascertained as the cause. Always qualify all  
diseases resulting from childbirth or miscarriage as  
"Puerperal septicæmia," "Puerperal peritonitis," etc.  
State cause for which surgical operation was under-  
taken. For violent deaths state means of injury  
and qualify as accidental, suicidal, or homicidal, or  
as probably such, if impossible to determine definitely.  
Examples: *Accidental drowning*; *Struck by railroad  
train—accident*; *Repetitive wound of head—homicide*;  
*Poisoned by certain food—probably suicide*. The na-  
ture of the injury, as fracture of skull, and conse-  
quences (e. g., *sepsis*, *lætemia*) may be stated under the  
head of "contributory." (Recommendations on state-  
ment of cause of death approved by Committee on  
Nomenclature of the American Medical Association.)

If this certificate is marked over thoroughly and all ques-  
tions answered in detail it will prevent further correspond-  
ence. If the data is essential and must be obtained before  
the certificate is permanently filed.

RECEIVED  
NOV 5 1930  
BUREAU



MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified--Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Aberdeen Proving Ground,

2 FULL NAME MARGARET ALVORD SPILLER

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH December 20th, 1891  
(Month) (Day) (Year)

7 AGE 38 yrs. 8 mos. 29 da. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) Housework

9 BIRTHPLACE (State or country) West Point, New York

10 NAME OF FATHER Benjamin Alvord  
11 BIRTHPLACE OF FATHER (State or country) Vancouver, Washington  
12 MAIDEN NAME OF MOTHER Margaret McCleery  
13 BIRTHPLACE OF MOTHER (State or Country) Peoria, Illinois

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver L. Spiller

(Address) Aberdeen Proving Ground, Md.

15 Filed Sept 20 19230 O. L. Spiller  
Registrar

10491

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. \_\_\_\_ Ward \_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 19th, 1930  
September (Month) 19 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug. 25 19230 to Sept 19, 19230

that I last saw her alive on September 19, 19230,

and that death occurred on the date stated above, at 12.10 P.m.

The CAUSE OF DEATH \* was as follows:

Carcinoma, of Intestines.

(Duration) 1 yrs. 6 mos. \_\_\_\_ da.  
Contributory None  
Secondary

(Signed) Joseph M. Mitchell for M.D.C.  
9-19-30 192\_\_\_\_ (Address) Aberdeen Proving Gd Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Unknown

19 PLACE OF BURIAL OR REMOVAL

Arlington, Va.

DATE OF BURIAL

Sept 22, 1930

20 UNDERTAKER

B. M. Mitchell

ADDRESS

Havre de Grace Md.

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, (e.g., fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hampford

Village or City Darlington (No. \_\_\_\_\_)

2 FULL NAME William Stanger

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Unknown 1 (Month) (Day) (Year)

7 AGE 40 yrs. Unknown mos. Unknown ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Bridge Man  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Unknown Stanger

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Donthumov

13 BIRTHPLACE OF MOTHER (State or Country) 11

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norman Ross  
(Address) Selinsgrove, Penna.

15 Filed Oct 24 1928 M. W. Kirk Registrar

12346

(185)

## STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 184

St: \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 24, 1928  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct. 24, 1928 to Oct. 24, 1928, that I last saw him alive on Oct. 24, 1928.

and that death occurred on the date stated above, at 12:41 P. M.

The CAUSE OF DEATH \* was as follows:  
Fracture of Skull.  
Fell from bridge.

(Duration) 45 minutes yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) M. E. Gallion M. D.  
Oct. 24, 1928 (Address) Darlington

\*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore DATE OF BURIAL \_\_\_\_ , 19\_\_

20 UNDERTAKER H. S. Bailey ADDRESS Darlington



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Iatrition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 8 1930  
BUREAU V. B.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Harford

Village or City

Harford Calverton near Bel Air Md.

Registration Dist. No.

182

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Eugene Stantard

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7 AGE

About 86 yrs.

mos.

ds.

If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Unknown

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Unknown

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Patrick

(Address)

Bel Air Md

15

Filed

July 14, 1930

NE Richardson

Registrar

16 DATE OF DEATH

July 13, 1930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1929 to July 13, 1930

that I last saw him alive on July 13, 1930

and that death occurred on the date stated above, at 9:15 p.m.

The CAUSE OF DEATH \* was as follows:

Per sepsis (Complete)

(Duration) yrs. mos. ds.

Contributory Secondary

Signed: Chas. P. Richardson M. D.

July 14, 1930 (Address) Bel Air Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harford Calverton July 14, 1930

20 UNDERTAKER

ADDRESS

Dean Foster Bel Air Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile society.* The maternal worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer. Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—occident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1930

BUR



WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Hartford

Village or City

Gallston

(No. \_\_\_\_\_)

2 FULL NAME

Dorothy Stenfeld

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

May 31, 1889

7 AGE

41  
51 yrs. 3 mos. 10 ds. or min.?IF LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work

House Work

(b) General nature of industry  
business, or establishment in  
which employed or (employer)9 BIRTHPLACE  
(State or country)

Baltimore, Md.

10 NAME OF  
FATHER

Theodore J. Stenfeld

11 BIRTHPLACE  
OF FATHER

(State or country) Baltimore, Md.

12 MAIDEN NAME  
OF MOTHER

Henrietta Fambman

13 BIRTHPLACE  
OF MOTHER

(State or Country) Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. E. Stenfeld

(Address)

Gallston, Md.

15

Filed

Sept 11, 1930

Registrar

10452

129

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in  
a hospital or institu-  
tion, give its NAME in-  
stead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

SEPT 11, 1930 (Month) 11 (Day) THUR (Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from  
1919 192 to SEPT. 11-30, 192

that I last saw her alive on SEPT. 10-30, 192 A.

and that death occurred on the date stated above, at 5.30 A.

The CAUSE OF DEATH \* was as follows:

CHRONIC VALVULAR DISEASE, NEPHRITIS,  
BRONCHIECTISContributory  
Secondary TOXAEMIA(Signed) Russell S. O'Leary M. D.  
Sept 11, 1930 (Address) EEL\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the  
State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Gallston, Md.

DATE OF BURIAL

Sept 15, 1930

20 UNDERTAKER

R. H. Burger &amp; Sons, Baltimore, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 7 1930  
BUREAU

1930  
5-1

89



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Near Havre de Grace (No. 45)

2 FULL NAME Annie M. Stephenson

05647 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE Widow  
Female White Widow  
(Write the word)

6 DATE OF BIRTH Nov. 15, 1860  
(Month) (Day) (Year)

7 AGE 70 yrs. 6 mos. 6 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Stephen B. Hanna

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Cassandra Griffin

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Lindell

(Address) Havre de Grace

15 Filed May 24, 1930 Bertha B. Knight  
deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 1929 to May 20, 1930  
that I last saw her alive on May 22, 1930

and that death occurred on the date stated above, at 8:30 P. m.  
The CAUSE OF DEATH \* was as follows:

Intestinal Obstruction

Contributory Secondary (Duration) 10 yrs. 10 mos. 10 ds.  
Carcinoma of Intestines

(Signed) Lee Hopwood M. D.  
May 24, 1930 (Address) Havre de Grace

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Rock Run Cem. DATE OF BURIAL May 25, 1930

20 UNDERTAKER H. S. Bailey ADDRESS Harlington



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renovator wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JUN 4 1901  
BUR



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1 PLACE OF DEATH

County HarfordSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180Village or City Abingdon (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Simon John Stiegler

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

March 29 2, 1888  
(Month) (Day) (Year)

7 AGE

75 yrs. 6 mos. 26 ds. or \_\_\_\_\_ min.?IF LESS than  
1 day \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Retired

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

George Stiegler

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Caloura Fischer

13 BIRTHPLACE OF MOTHER

(State or Country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

4206 Roland av. Balto.  
George N. Stiegler

15

Filed Oct 26 1930 Fred Sharlat  
local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 25, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Oct 25 to Oct 25, 1930that I last saw him alive on \_\_\_\_\_, 1930,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Found dead - No mark  
of evidence of foul play  
Probable cause of death  
(Heart disease)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Oct 25 1930 (Address) Balto. Md.

\*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

10/28, 1930

20 UNDERTAKER

Mrs. Weber & Son

ADDRESS

3503 Edmond



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mescalies; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mescalies* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident, Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 4 1930  
BUREAU



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## 1 PLACE OF DEATH

County HowardVillage or City Pylesville (No. \_\_\_\_\_, St. \_\_\_\_\_ Ward \_\_\_\_\_)

## 2 FULL NAME

Mary M. StultzRegistration Dist. No. 184

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED married  
(Write the word)

## 6 DATE OF BIRTH

Feb 7 1866  
(Month) (Day) (Year)

## 7 AGE

64 yrs. 11 mos. 18 ds. or 18 min.  
If LESS than 1 day....hrs.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

## 9 BIRTHPLACE

(State or country) md

## PARENTS

## 10 NAME OF FATHER

David G. Butler

## 11 BIRTHPLACE OF FATHER

(State or country) md

## 12 MAIDEN NAME OF MOTHER

Mary R. Bartoe

## 13 BIRTHPLACE OF MOTHER

(State or country) md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jae Stultz(Address) Pylesville md

## 15

Filed Jan 24 1980 J. J. McRabb  
Registrar0524 STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan. 26 1980  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended the deceased from

Jan. 22 1980, to Jan 24 1980  
that I last saw her alive on Jan 24 1980and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH was as follows:

DiphtheriaContributory  
Secondary(Duration) 3 yrs. .... mos. .... da.

(Duration) .... yrs. .... mos. .... da.

(Signed) Charles W. Barry

M.D.

Jan 26 1980 (Address) Strat Rd md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .... yrs. .... mos. .... da. In the State, .... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Farm Lane Rd. Jan 28 1980

## 20 UNDERTAKER

## ADDRESS

J. J. McRabb Farm Lane Rd



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (c) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 30 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1930

BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

Village or City Street R.F.D. (No. 1)

2 FULL NAME Wm. H. Stoker

04399

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 184

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Feb. 18, 1877  
(Month) (Day) (Year)

7 AGE 53 yrs. 1 mos. 24 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) North Carolina

10 NAME OF FATHER Wm. Stoker

11 BIRTHPLACE OF FATHER (State or country) M. C.

12 MAIDEN NAME OF MOTHER Ann Stoker

13 BIRTHPLACE OF MOTHER (State or Country) M. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Wm. Stoker

(Address) Street, Md. R.F.D.

15 Filed April 12 1928 M. W. Kink Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 11, 1928  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar. 20, 1928 to April 11, 1928

that I last saw him alive on April 11, 1928

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH \* was as follows:  
organic heart disease

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Charles W. Thomas M. D.

April 12 1928 (Address) Street R.F.D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Emory Cem. DATE OF BURIAL April 13, 1928

20 UNDERTAKER H. S. Bailey ADDRESS Wilmington, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architecl, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report, specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Hanford

Village or City New Riverdale

2 FULL NAME Lel Strawbridge

10493

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 183

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH July 19 1873  
(Month) (Day) (Year)

7 AGE 57 yrs. 1 mos. 25 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housekeeper  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Pa

10 NAME OF FATHER John Hunsberger

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Sandra Coats

13 BIRTHPLACE OF MOTHER (State or country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Viola Strawbridge

(Address) Farm Grove Pa

15 Filed Sept 16 1930 Thomas P. Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 13 1930  
(Month) 13 (Day) (Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from Sept 7 1930 to Sept 12 1930  
that I last saw her alive on Sept 12 1930

and that death occurred on the date stated above, at 8:30 P.m.  
The CAUSE OF DEATH \* was as follows:

hypertension  
myocarditis  
apoplexy

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Norman H. Kemmell M. D.  
Sept 15 1930 (Address) Stewartstown, Pa.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bertha Cemetery Pa Sept 17 1930

20 UNDERTAKER ADDRESS

H. H. Webb Farm Grove Pa



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Retarder wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 7 1904

BUREAU



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1 PLACE OF DEATH

County Hanford

13866

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 180Village or City Bear (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Cassanova Stett

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 ~~SINGLE.~~  
~~MARRIED.~~ widowed  
~~OR DIVORCED~~  
(Write the word)

6 DATE OF BIRTH April 1st, 1864  
(Month) (Day) (Year)

7 AGE 66 yrs. 7 mos. 10 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER E. H. Richardson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alma Anna Welsch

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. C. Lousch(Address) Bear Maryland

15 Filed Nov 11 1930 Fred H. Hark  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 10th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 10th, 1930 to Nov 10th, 1930  
that I last saw him alive, on Nov 10th, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis  
Myocarditis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) Chas. Richardson M. D.  
Nov 10th 1930 (Address) Bear MD

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Chesville Presbyterian Church Nov 12, 1930

20 UNDERTAKER ADDRESS

Howard K. McComas Abingdon Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asithemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 3 1930

BUREAU



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1 PLACE OF DEATH  
County Harpard.

Village or City Talbot (No. \_\_\_\_\_)

2 FULL NAME Anna L. Sullivan

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married.  
(Write the word)

6 DATE OF BIRTH April 24, 1882  
(Month) (Day) (Year)

7 AGE 58 yrs. 11 mos. 26 ds. or 76 ds. If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House Wife.  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER John Bradley.

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hannah McCuskey

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Robt. Sullivan.

(Address) Talbot, Md.

15 Filed Apr 21 1930 N. E. Richardson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 19, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 1, 1930 to April 19, 1930.

that I last saw her alive on April 19, 1930.

and that death occurred on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH \* was as follows:

Broncho-pneumonia  
terminating Bronchitis  
Asthma + Heart Disease

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 8 ds.

Contributory Chr. Myocardial Disease  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Willard P. Hudson M. D.  
April 21, 1930 (Address) Four Hill, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St. John's Cath Cen DATE OF BURIAL Apr 22, 1930.

20 UNDERTAKER Honley & Cross ADDRESS Boston, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Rencher wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be completed before the certificate is permanently filed.

14700  
58  
82

FILED  
JUN 10 1914  
U. S. DEPT. OF COMMERCE  
BUREAU OF VITAL STATISTICS



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Harford*

WITHIN CORPORATE LIMITS OF

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *185*Village or City *Old Grace* (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Rose F. Sumption*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*white*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*widowed*

6 DATE OF BIRTH

*December 9 - 1845*  
(Month) (Day) (Year)

7 AGE

*84 yrs. 10 mos. 17 ds.*  
If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

*Housework*

9 BIRTHPLACE

(State or country)

*Maryland*

10 NAME OF

FATHER

*Samuel L. Wheeler*

11 BIRTHPLACE

OF FATHER

(State or country)

*Maryland*

12 MAIDEN NAME

OF MOTHER

*Susan Holland*

13 BIRTHPLACE

OF MOTHER

(State or Country)

*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Miss Sue Sumption**Old Grace, Md.*

15 Filed

*Oct. 29 1920*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*October 27<sup>th</sup> 1920*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from *Oct. 14<sup>th</sup> 1920* to *Oct. 27<sup>th</sup> 1920*that I last saw her alive on *Oct. 26<sup>th</sup> 1920*and that death occurred on the date stated above, at *6-a* m.

The CAUSE OF DEATH \* was as follows:

*Cerebral Hemorrhage*(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. *14* ds.Contributory  
Secondary*Arterio-Sclerosis*(Duration) *5* yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

*James B. Boy* M. D.  
*Oct. 28<sup>th</sup> 1920* (Address) *Wm. Dr. E. E. ind*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Angel Hill Cemetery* *Oct. 29, 1920*

20 UNDERTAKER

ADDRESS

*Summington Son Old Grace Md.*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrub, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1930  
BUREAU



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND	
County <u>Harford</u>			CERTIFICATE OF DEATH	
Village or City <u>Harrods Grace</u> (No. <u>Hospital</u> )			Registration Dist. No. <u>185</u>	
2 FULL NAME <u>John Command Salik</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>		
6 DATE OF BIRTH <u>about</u> <u>1881</u> (Month) (Day) (Year)				
7 AGE <u>49</u> yrs. <u>4</u> mos. <u>1</u> day <u>1</u> hrs. <u>1</u> min. If LESS than 1 day				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer)				
9 BIRTHPLACE (State or country) <u>Md.</u>				
PARENTS	10 NAME OF FATHER <u>John Command Salik</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>			
	12 MAIDEN NAME OF MOTHER <u>L. Ann Fullerton</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James J. Salik</u> (Address) <u>Harrods Grace Md.</u>				
15 Filed <u>June 16 1930</u> <u>Chas. J. Foley, M.D.</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>June 14 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>May 20 1930</u> to <u>June 14 1930</u> , that I last saw him alive on <u>June 14 1930</u> , and that death occurred on the date stated above, at <u>1 P.</u> m.				
The CAUSE OF DEATH * was as follows: <u>Chronic diffuse nephritis</u> (Duration) yrs. mos. ds.				
Contributory Secondary (Duration) yrs. mos. ds.				
(Signed) <u>W. Lewis</u> M. D. <u>6-15 1930</u> (Address) <u>Harrods Grace Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.				
Where was disease contracted, if not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Angel Hill Cem</u>				DATE OF BURIAL <u>6/16 1930</u>
20 UNDERTAKER <u>Madison M. H. G.</u>				ADDRESS <u>Md.</u>



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return 'Laborer,' 'Foreman,' 'Manager,' 'Dealer,' etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia, "PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A true date is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 3 1930  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

near Bel Air Md.

## 2 FULL NAME

Louis Say

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

## 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

## 6 DATE OF BIRTH

About 1852  
(Month) (Day) (Year)

## 7 AGE

About 78 yrs. mos. ds. or min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

## 9 BIRTHPLACE (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15

Filed June 5 1930, H. E. Chambers  
Deputy Registrar

06778

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 182

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

June 6<sup>th</sup> 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1928 to June 5, 1923

that I last saw him alive on May 31, 1923

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Coronary Atherosclerosis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

June 5 1923 (Address) Bel Air Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

County Anne June 5, 1930

## 20 UNDERTAKER

## ADDRESS

Dean Foster Bel Air Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Harford

WITHIN CORPORATE LIMITS OF

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

Village or City Harwood House (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alderman B. Sentman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Jan. 3, 1860  
(Month) (Day) (Year)

7 AGE 70 yrs. 6 mos. 17 ds. or 1 day 1 hrs. 1 min.?  
If LESS than

8 OCCUPATION  
(a) Trade, profession or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed or (employer) Contractor

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Eli Sentman

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Jackson

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank B. Sentman

(Address) Portable Post, Md.

15 Filed June 21, 1930 Charles J. Foley, M.D.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 19, 1930 to June 20, 1930, that I last saw him alive on June 19, 1930, and that death occurred on the date stated above, at 12:10 A.M.  
The CAUSE OF DEATH \* was as follows:

Congestive Failure

Contributory Secondary (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) F. M. Steiner M. D. June 20, 1930 (Address) Harwood House, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Principio Cem. June 22, 1930

20 UNDERTAKER ADDRESS

Lee A. Patterson Berryville, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. B.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Haitford

Village or City

Edgewood

(No. \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 180

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Stauffer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Infant

6 DATE OF BIRTH

June 19, 1930  
(Month) (Day) (Year)

7 AGE

yrs. mos. ds. or min.?

If LESS than 1 day 5 hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Emanuel Stauffer

11 BIRTHPLACE OF FATHER

(State or country)

New Jersey

12 MAIDEN NAME OF MOTHER

Verna Berne

13 BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emanuel Stauffer

(Address)

Edgewood

15

Filed

June 20, 1930

Fred Charlote  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 20, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 4 a. m.

The CAUSE OF DEATH \* was as follows:

Premature Birth  
(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Charles R. M. D.

June 20, 1930 (Address) Edgewood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Edgewood Arsenal

June 20, 1930

20 UNDERTAKER

ADDRESS

Howard K. McNamee

Abingdon



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 2 1900  
BUREAU



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Harford

Village or City Pikeville No. \_\_\_\_\_

2 FULL NAME Charles Edward Strawbridge

06781

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 184

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH May 13 1861  
(Month) (Day) (Year)

7 AGE 69 yrs. 1 mos. 0 ds. or \_\_\_\_\_ min.?  
IF LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Prob Strawbridge

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Elizabeth Payne

13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. S. Strawbridge

(Address) Pikeville Ind

15 Filed June 16 1930 J. B. S. M. H. H. H.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June - 13 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1 1929 to June 13 1930  
that I last saw him alive on June - 13 1930

and that death occurred on the date stated above, at 3 P. m.  
The CAUSE OF DEATH \* was as follows:

Apoplexy

(Duration) \_\_\_\_\_ yrs. 11 mos. \_\_\_\_\_ ds.  
Contributory Same  
Secondary \_\_\_\_\_

(Signed) Vallie Hackett M. D.  
June - 14 - 1930 (Address) Farm Grove - Pa.

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Gatchsville Pa DATE OF BURIAL June 14 1930

20 UNDERTAKER J. H. Webb Farm Grove Pa ADDRESS \_\_\_\_\_



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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JUL 2 1930

BUREAU



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1 PLACE OF DEATH  
County Harford

Village or City Harford General Hospital

2 FULL NAME William Styles

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) unbrow

6 DATE OF BIRTH unbrow, 1889  
(Month) (Day) (Year)

7 AGE 41 yrs. 0 mos. 0 ds. or 0 min. If LESS than 1 day 0 hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Elmer E. Styles

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER May Gainer

13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Tyson  
(Address) Rising Sun, Ind.

15 Filed July 29 1930 Charles J. Foley, M.D.  
Registrar

08095

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 29th, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 28, 1930, to July 28, 1930, that I last saw him alive on July 28, 1930

and that death occurred on the date stated above, at 6:15 P.M.  
The CAUSE OF DEATH \* was as follows:

Meningitis.  
Possibly from Peric  
tonsitis. (Duration)      yrs.      mos.      ds.

Contributory  
Secondary

(Signed) [Signature] M. D.  
7-29 1930 (Address) Harford, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Harmony Chapel Md. DATE OF BURIAL Aug 1, 1930

20 UNDERTAKER J. E. Tyson ADDRESS Rising Sun, Ind.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			08096 188-c		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Harford</u>			Registration Dist. No. <u>125</u>			
Village or City <u>Havre de Grace</u> (No. ....)			St. ....		Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John Sudow</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>				
6 DATE OF BIRTH <u>August 29<sup>th</sup> 1904</u> (Month) (Day) (Year)						
7 AGE <u>25</u> yrs. <u>10</u> mos. <u>5</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Carpenter (or Carpenter Helper)</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>at Edgewood Arsenal Md</u>						
9 BIRTHPLACE (State or country) <u>Nantico, Pennsylvania</u>						
PARENTS	10 NAME OF FATHER <u>Unknown</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>					
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>M Marshall</u>						
(Address) <u>Edgewood Arsenal Md</u>						
15 Filed <u>July 9 1920</u> <u>6 hr. J. Fly, M.D.</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>July 4<sup>th</sup> 1920</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>July 4 1920</u> to <u>July 4 1920</u> , that I last saw him alive on <u>July 4 1920</u> , and that death occurred on the date stated above, at <u>5:45 P.m.</u>						
The CAUSE OF DEATH * was as follows: <u>Automobile accident. Car on</u> <u>Fracture 3rd &amp; 4th</u> <u>Cervical vertebrae</u> <u>In front of Dr. Painter's store, Philadelphia Road</u> <u>Contributory</u> <u>Alcohol &amp; Reflex togeth.</u> <u>Secondary</u> (Duration) .... yrs. .... mos. .... ds.						
(Signed) <u>Martin P. Foley "Coroner"</u> M. D. <u>July 5<sup>th</sup> 1920</u> (Address) <u>Havre de Grace, Md</u>						
State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place <u>1 1/2 hours at Havre de Grace</u> In the State .... yrs. .... mos. .... ds. Where was disease contracted, if not at place of death? .... Former or usual residence .....						
19 PLACE OF BURIAL OR REMOVAL <u>Nantico Pennsylvania</u>						DATE OF BURIAL ....., 19.....
20 UNDERTAKER						ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Harford</u> WITHIN CORPORATE LIMITS OF		57 01743		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hdelsrace</u> (No. ....)		St. .... Ward ....		Registration Dist. No. <u>185</u>	
2 FULL NAME <u>Jennie L. Sutor</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>September 11, 1861</u> (Month) (Day) (Year)					
7 AGE <u>68</u> yrs. <u>5</u> mos. <u>14</u> ds. or LESS than 1 day .... hrs. .... min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry business, or establishment in which employed or (employer) .....					
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>					
PARENTS	10 NAME OF FATHER <u>Michael Claguen</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u>				
	12 MAIDEN NAME OF MOTHER <u>Rebecca Jones</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Pennsylvania</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. Nicola Sutor</u> (Address) <u>Hdelsrace, Md.</u>					
15 Filed <u>Mar. 1, 1930</u> <u>Chas. J. Foley, M.D.</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Feb 26, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>June 1, 1926</u> to <u>Feb 26, 1930</u> that I last saw her alive on <u>Feb 26, 1930</u> , and that death occurred on the date stated above, at ..... m. The CAUSE OF DEATH * was as follows: <u>Diabetes Mellitus</u> <u>Acute Nephritis</u> (Duration) ..... yrs. .... mos. <u>6</u> ds. Contributory <u>Cardiac Failure</u> Secondary (Duration) ..... yrs. .... mos. <u>2</u> ds. (Signed) <u>Chas. J. Foley, M.D.</u> <u>2/26/1930</u> (Address) <u>Harford, Md.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds. Where was disease contracted, if not at place of death? .....					
Former or usual residence .....					
19 PLACE OF BURIAL OR REMOVAL <u>Angel Bleeche</u>				DATE OF BURIAL <u>Feb. 4, 1930</u>	
20 UNDERTAKER <u>Penningtonson</u>				ADDRESS <u>Hdelsrace, Md.</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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MAR 6 1930  
BUREAU OF  
VITALS